Health Canada Santé Canada

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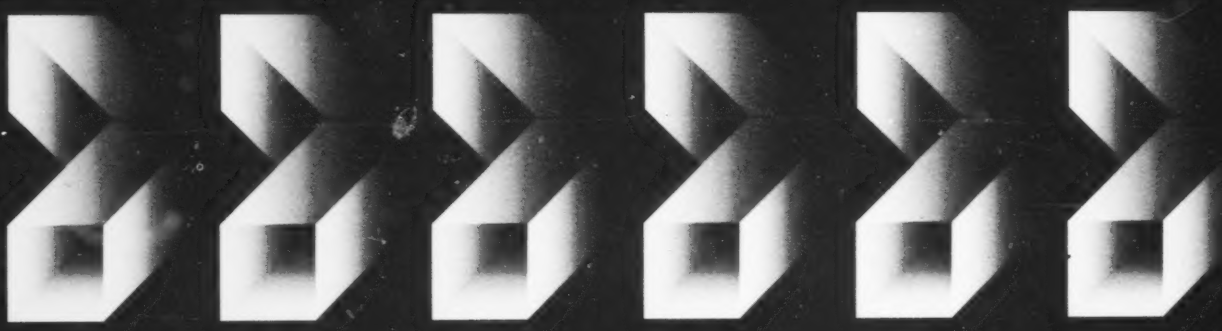

EVALUATION OF HEALTH CANADA'S CONTRIBUTIONS TO CANADA'S DRUG STRATEGY

FINAL FIELD WORK REPORT

December 1996

Canada

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EVALUATION OF
CANADA'S DRUG STRATEGY

HEALTH CANADA

FINAL FIELD WORK REPORT

Prepared for the
Evaluation Group
Strategic Planning & Review Directorate
Health Canada

by Jamieson, Beals Lalonde & Associates
Contract No. H1021-6-09632

18 December 1996

This document has been prepared by Jamieson Beals Lalonde & Associates. The analysis, conclusions and recommendations in this document are those of Jamieson Beals Lalonde & Associates and do not necessarily reflect the views or policies of Health Canada or the Government of Canada.

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PREFACE

This report captures the results of all of the field work undertaken to evaluate the Health Canada component of the Canada Drug Strategy Phase II. The field work was conducted from May 1996 to August 1996. The report includes:

Part I:	A review of key documents pertaining to the Health Canada component of the CDS Phase II.
Part II:	A review of literature that has been produced on substance abuse prevention programming and high risk populations over the past five years.
Part III:	The results of our interviews with Health Canada's external partners in the CDS Phase II, including subject matter experts, provincially-based partners and stakeholders.
Part IV:	The results of our interviews with Health Canada officials and its federal partners.

These reports served as the information base during the analysis and preparation of the Final Evaluation Report.

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PART I: DOCUMENT REVIEW REPORT

December 18, 1996

Jamieson, Beals, Lalonde and Associates, Inc.

I. INTRODUCTION

Purpose

The document review is intended to:

- ensure that the Project Team has a common and up-do-date understanding of the Health Canada CDS Phase II;
- help us to identify evaluation issues worthy of further exploration;
- help us to shape the literature review and interview guides; and
- provide preliminary evidence on the evaluation questions.

It is important to note that this report does not, and was not expected to, provide a complete or detailed portrait of all Health Canada activities undertaken under CDS Phase II. Rather, this report serves as a working tool for the evaluation team at the beginning of the study. It is intended to provide a preliminary outline of CDS activities, prior to conducting the field work phase of the study. Health Canada CDS program personnel have been given an opportunity to review this document and provide some further input, on the understanding that the contents of this document will be further verified during the field work stage, e.g. the interviews will be used to fill gaps, confirm and clarify the developments and issues identified in the document review, and to obtain relevant context.

It is also important to note, based on the observations of Health Canada officials consulted during preliminary interviews, that the Mid-Term Review Report of the Health Canada component of the CDS[1] may be limited in terms of being an accurate reflection of CDS, for a variety of reasons. The mid-term review was conducted in early 1994, and focused on process/implementation issues, many of which related to coordination. Some Health Canada program officials are of the opinion that the mid-term review was somewhat premature and thus not reflective of the progress made in various areas. In reviewing the Mid-Term Review Report, we have taken these concerns under advisement. Issues identified in the Mid-Term Review Report and mentioned in this report will be further explored as to their accuracy and relevancy during the conduct of our field work.

Review Process

On-site document reviews took place in three locations: the Office of Alcohol, Drugs and Dependency Issues (Health Promotion and Programs Branch), Health Programs Support Division (HPSD, Medical Services Branch) and the Bureau of Drug Surveillance (Health Protection Branch). The Canadian Centre on Substance Abuse and NHRDP (HPPB) also provided documents for review.

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[1] Health Canada, Evaluation Group, Policy and Consultation Branch (June 1995) *Mid-Term Review Report: Health Canada's Contributions to Canada's Drug Strategy.*

Given time, travel, and resource constraints, the document review process focused on covering as many of Health Canada's CDS components as possible. Several areas were not included in the document review, including the following:

The Bureau of Drug Research, HPB
Regional Operations, HPB
Regional Offices, HPPB
Regional Offices, MSB
Education and Training Unit, HPD (original name of component)
Studies Unit, HPD (original name of component)
Program Promotion Division (original name of component)

Representatives of each of these areas were interviewed during the evaluation (see Part I, Appendix E and Part IV, Appendix A). In some cases, they were asked to provide specific documentation, in addition to the interviews, e.g. some groups were asked for financial information related to the allocation of resources to target populations.

How this Report is Organized

This report is organized according to the evaluation questions. It provides a summary of the evidence from the documents (as well as additional information provided by Health Canada personnel during the document review process); a preliminary analysis of the findings; identification of issues to be further explored during the evaluation; and an outline of the evaluation's "next steps".

II. FINDINGS

Enhanced Programming

✓ How was Canada's Drug Strategy intended to strengthen HC's programming in prevention and enforcement and control?

Evidence in documents

According to the RFP, the CDS was intended to improve programming through the following four strategies: improved targeting, improved coordination, enhanced information, and the allocation of resources.[2]

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[2] Rather than summarize the MC and the TB Submission, we have referred to the RFP because it indicates that the Evaluation Working Group and the Program Working Group (in discussion with CDSS) "reconstructed" the ideas contained in the MC and the TB Submissions.

As part of targeting at risk populations, Phase II was to broaden partnerships in the area of substance abuse in a harm reduction context. This was considered essential to meeting the needs of at risk groups.

These four strategies were "operationalized" into specific activity areas for the Health Canada CDS component as outlined in the Memorandum to Cabinet, the Treasury Board Submission, and the NHW Evaluation Framework[3] developed in 1992. In addition, the Health Promotion Directorate undertook a strategic planning exercise which further delineated CDS activity areas. Tables comparing the activity areas specified under CDS, identifying which activities appear to have been undertaken, and outlining the shifts expected in Phase II, are provided in Appendix A.

Preliminary Analysis and Possible Evaluation Issues

HC has implemented each of the four strategies to strengthen prevention and enforcement/control programming. In general, the activity areas outlined in the TB Submission appear to have been undertaken.

Possible Issue: *How appropriate were these strategies as a means to strengthen prevention/enforcement/control programming?*

Further Action for Evaluation

The interviews will explore interviewees' understanding of these strategies, and how they were to result in strengthened prevention/enforcement/control programming, as well as the extent to which this was accomplished.

✓ *What changes have there been, if any, to prevention, enforcement and control programs under the CDS?*

Evidence in documents

Prevention

Improved Targeting

The major change to prevention programs under CDS relates to the targeting of at risk populations, and includes the following shifts:

- The targeting of the majority of demand reduction programs and activities to specific at risk population groups.

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[3] Health and Welfare Canada, Program Evaluation Division (March 1993) *Framework for Evaluating Canada's Drug Strategy, Phase II*.

- The development and formalization of extensive networks/partnerships in order to coordinate and collaborate on the development of prevention programs and demand reduction strategies for specific at risk population groups.

- The development of enhanced information of programming for target populations, (i.e. regarding existing resources/programs and appropriate approaches to targeting at risk population groups).

- The enhancement of "big picture" information on substance abuse in Canada to include at risk populations i.e. youth, women, seniors, urban aboriginal peoples, and first and repeat impaired driving offenders.

Improved Coordination

Varying amounts of coordination and collaboration appear to have taken place under Phase II at different levels, i.e. some regional/community level coordination under the Community Support Program; significant Branch level coordination (within HPPB) re: policy and program development; some departmental level coordination on specific policy issues and/or legislation; federal/provincial/territorial coordination on research, policy and programming issues; significant national level collaboration/coordination between representatives of target populations and those involved in substance abuse programming/policy development[4]; significant interdepartmental coordination in specific policy areas; significant interdepartmental coordination re: international level issues. See Appendices B and C for a list of coordination mechanisms developed under CDS Phase II.

Improved Information Base

Phase II appears to have enhanced the overall information base on substance abuse in Canada. Major examples include the development of Canada's Alcohol and Other Drugs Survey, The Costs of Substance Abuse in Canada study, and the Canadian Community Epidemiology Network on Substance Abuse. Please also see Appendix E for the database review report.

Resources

According to the Mid-Term Review Report, Phase II resources were allocated to prevention programming, although a smaller percentage than in Phase I (60% compared to 70% under Phase I).

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[4] Departmental personnel indicated that NGOs and community action groups figured prominently in CDS collaboration and coordination.

Enforcement/Control

Improved Targeting

Some of Health Canada's enforcement and control activities targeted health professionals, for example, in terms of enhancing their role in preventing the abuse of licit drugs.

Improved Coordination

The document review did not provide evidence of the extent to which coordination of enforcement and control programming was improved/changed under CDS. (The Mid-Term Review Report noted that, interdepartmentally and internationally, coordination among players involved in enforcement and control programming was well established prior to CDS.)

Improved Information Base

From the documents reviewed, it appears that the information system operated by BDD was enhanced under the CDS.

Resources Allocated

Resources were allocated to enforcement/control programming under Phase II. (At the time of writing, the financial information on this aspect was incomplete).

Preliminary analysis and possible evaluation issues

The targeting of at risk populations has clearly been the major change in Health Canada's substance abuse prevention programming. The impact of this exercise appears to be both significant and widespread, in terms of the number and scope of national and community-level projects undertaken.

We note that many of Health Canada's enforcement and control related activities were apparently taking place prior to the implementation of Phase II CDS. Possible contributions of Health Canada's CDS component to control/enforcement may include: enhanced impact on existing activities; enhanced collaboration departmentally and in the field (i.e. between prevention and control/enforcement players) and (interdepartmentally) on control/enforcement related issues of national and international import, as well as the possible targeting of some activities to at risk populations.

Further action for evaluation

The interviews will further clarify the impacts of targeting, as well as the other changes in coordination, information enhancement and allocation of resources. There may also have been significant non-CDS factors that have prompted changes in Health Canada programming (i.e. resource cuts, organizational change, program review, etc.), which the interviews will capture.

✓ Have Health Canada's prevention, enforcement and control programs become more cost-effective?

Evidence in documents

The documents reviewed did not provide this information. See questions on resources.

Preliminary analysis and possible evaluation issues

Cost-effectiveness appears to be one of the underlying goals of the targeting approach to programming, i.e. targeting resources to at risk populations is more effective (including in terms of cost) than the "scatter gun" approach of targeting the general population.

CDS resource information was not maintained in a consistent and easily accessible manner by the programs. Consequently, it may be difficult to arrive at a judgement as to the cost-effectiveness of programming based on financial data[5].

Further action for evaluation

Our ability to answer this question will depend, at least to some extent, on the final financial data provided by Health Canada. As well, the assessment of cost-effectiveness will be based on subjective opinions provided by interviewees.

✓ Are there clear lines of accountability within the Department for CDS initiatives and the CDS strategy as a whole? .

Evidence in documents

The documents indicate the following situation:

- No up-to-date organizational chart for HC CDS component is available.

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[5] The feasibility of determining the cost-effectiveness of Phase II activities, (for example, as compared to Phase I) poses many methodological challenges; at a minimum, opinion-data on cost-effectiveness will be collected during the interview phase of this study.

- Based on the documentation reviewed, much of the original coordinating infrastructure (CDSS, ADM Steering Committee, CDS Interdepartmental Working Group) has either been dismantled or does not appear to have been active recently (CDSS was downsized in 1995 and dismantled in March 1996; the ADM Steering Committee appears to have met once (June 1996) since December 1994[6]; the CDS Interdepartmental Working Group does not appear to have met since late 1994.[7] The interdepartmental coordination function has now been assumed by the OADDI.
- There has been extensive organizational change within Health Canada since Phase II began, and the reporting structures with HPPB and HPB have changed significantly.
- The decentralized structure of MSB means the Regional Offices do not regularly report on CDS activities to the National level component of CDS. (Regional offices do, however, advise other Regions and the National office of their CDS activities at the Regional NNADAP Consultants meetings which occur 2-3 times a year.)

Preliminary analysis and possible evaluation issues

Despite the extent of organizational change within Health Canada (within HPPB and HPB particularly), combined with the discontinuation of the CDSS, many of the CDS activities have continued intact. For an outline of the location of current CDS HC components, please see Appendix D.

CDS accountability consists of regular departmental lines of authority and reporting relationships within the specific centres of responsibility.

Within MSB, regional offices are not required to regularly report to the national office on their CDS activities.

Possible Issue:	*Organizational change and ensuing changes in reporting structures may have had impacts on the lines of accountability for CDS.*
Possible Issue:	*The decision not to request a renewal of CDS may have impacted on the lines of accountability.*
Possible Issue:	*The decentralized structure of MSB may have had an impact on the lines of accountability for the Initiative.*

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[6] According to Departmental personnel, the ADM Committee was only expected to meet once or twice per year. The next meeting is scheduled for November 1996.

[7] According to Departmental personnel, the Interdepartmental Working Group as such did not meet after 1994, however a smaller interdepartmental group apparently met to discuss consultations for renewal up to July 1995. The Working Group has met on a regular basis since June 1996.

Further action for evaluation

Accountability will be addressed via interviews.

Improved Program Targeting

✓ ***Have programming targets changed under the CDS?***

Evidence in documents

Yes. The Memorandum to Cabinet indicated that high risk populations were to be targeted. According to the documents reviewed, the shift to targeting specific at risk populations has definitely taken place in HPPB programs and, to some extent, in MSB programs.

Preliminary analysis and possible evaluation issues

HPPB

In a strategic planning exercise conducted in late 1992, HPPB refined the MC suggestions for target groups[8] and adopted five high risk populations as the target groups under CDS.

Possible Issue: *To what extent have projects and grants and contributions focused on the five target groups identified during the strategic planning exercise? What has been the relative emphasis on each population group?*

MSB

Yes. A program for off-reserve Aboriginal was created under CDS. It is not clear at this point, however, the extent to which CDS regional level programming for on-reserve Aboriginal populations targeted Aboriginal youth.

Possible Issue: *To what extent have regional on-reserve CDS programs targeted Aboriginal youth?*

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[8] The selected target groups are also linked to a national consultation on the National Drug Strategy that took place in 1991, prior to CDS Phase II approval.

HPB

Maybe. According to HPB personnel, some HPB activities did involve targeting, at least to some extent. The Mid-Term Review Report noted that HPB's targeting of health professionals was in place prior to CDS Phase II.

Possible Issue: *To what extent did HPB target at risk population groups in its activities?*

Further action for evaluation

The interviews with program personnel will assist in identifying the extent to which at risk populations have been targeted under CDS.

✓ *How have programming targets changed?*

Evidence in documents

HPPB

Note: There are two main areas of activity within HPPB: 1) national level activities (e.g. education and training, research, social marketing, collaborative policy and program development, coordination, international cooperation) and those of the Community Support Program (national and regional components) originally located in the Health Promotion Directorate, and 2) the activities of NHRDP.

Targeting of HPD programming

HPD targeted its programs based on its own list of target groups, presented as listed in its strategic planning document:

▸ **Children, Youth and Young Adults**[9]

Particularly,
- "out of the mainstream" youth (OOMY) such as school dropouts, the homeless, runaways and street youth, those in homes where family violence is occurring[10]
- those who need to develop coping skills or improve their self-esteem.

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[9] For the purpose of Canada's Drug Strategy Phase II, children are persons aged 7 to 12 (Brighter Futures, another federal program deals with children age 0-6). Youth are persons aged 13-17 and young adults are aged 18-24.

[10] Note: these are not necessarily mutually exclusive categories.

- **Women**

Particularly,
- those who misuse prescription and/or non-prescription drugs, or alcohol, or combine drugs and alcohol;
- those who may use alcohol and/or other drugs during pregnancy.

- **Seniors**

Particularly,
- adults over 55 years of age who misuse prescription and/or non-prescription drugs, or alcohol, or combine drugs and alcohol.

- **Off-Reserve Aboriginal People**

Particularly,
- Métis, Inuit and Indian people who are not living on a reserve and who have specific concerns related to alcohol and/or other drugs.

- **Persons who drive while under the influence of alcohol and/or other drugs**

Particularly,
- persons who have previously driven while impaired, and who are at risk of doing so again.[11]

The Mid-Term Review Report noted that the shift to at risk populations was difficult for the social marketing area of HPPB because they were used to tailoring and disseminating information for the general population, and their funding criteria were also designed for general population type projects (and people in communities were used to preparing these kinds of proposals).

The Mid-Term Review Report also noted that social marketing activities had only begun to target OOMY[12] and Aboriginal, but not the other three groups. As well, the report notes that the Education and Training Unit, HPD had difficulties targeting these groups because of the shift away from program delivery in the schools. The Unit had not yet developed new programs because of the need to establish new partnerships and venues for delivery, and to seek effective programs.

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[11] Health Canada, Health Promotion Directorate (February 26, 1993) Canada's Drug Strategy Phase II Strategic Planning for 1993-1997.

[12] According to Departmental personnel, at this time, the priority established for special attention among the five high risk groups was youth.

The Mid-Term Review Report also noted that targeting social marketing efforts will require considering at risk groups such as OOMY as a "special case" rather than just as a subset of the general population.

It's clear that the strategic planning document developed by HPD identified specific target populations early in Phase II. The development of the Plan was a collaborative exercise which was also based on "an analysis of emerging patterns and trends and a national consultation in 1991." In addition, the Community Support Program re-did its funding guidelines early in Phase II to show the new target groups eligible for funding.

Based on activity profiles produced by the Office of Alcohol, Drugs and Other Dependency Issues, projects at the national level (including OADDI, Education and Training Unit, Programs Promotion Division, and the national component of the Community Support Program) addressed the following target groups (Please note: numbers are approximate and are included here only to demonstrate the relative weighting of projects to each target group in general terms, based on information available at the time of the document review.):

Out of the mainstream youth (OOMY) (13 projects)

- Eight (8) projects target service providers (and educators) who work with OOMY. [13]
- Four (4) projects target OOMY directly. [14]
- Street-Involved People/HIV (1 project)

Children/Youth/Young Adults (19 projects)

- Fourteen (14) other projects target youth in general, with two projects also targeting adults/parents.[15]
- One (1) project targeted post-secondary students.[16]

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[13] One project is the OOMY Community Development Project which supports communities in assessing their OOMY service and program needs/planning needs. Another is a field search/literature review on peer helper programs for OOMY. A third is a study on the antecedents of adopting a street lifestyle, plus their situation while on the street and the transition process to social stability. A fourth is international in scope and deals with training manuals, monitoring and evaluation for street workers. The fifth involves a network of service providers to share information on OOMY.

[14] One is a demonstration project in a community school with high risk youth; two are promotional events/campaigns (both of which also target a general audience) and one is a series of OOMY-specific community-based social marketing projects.

[15] These projects are primarily social marketing, promotional events/campaigns and/or media strategies.

[16] Via knowledge building/dissemination for trainers, coordinators and bar managers on campuses.

- Four (4) projects targeted children and youth indirectly (i.e. through significant others). [17]

Seniors (10 projects)

- Ten (10) projects target seniors and/or those organizations/agencies involved in working with seniors. [18]

Aboriginal People (15 projects)

- Four (4) projects indicate a specific focus on the off-reserve Aboriginal population.[19]
- One (1) project focused on the needs of off-reserve Aboriginal youth.[20]
- Two (2) projects focused on the needs of Aboriginal women. [21]
- Eight (8) projects focused on Aboriginal people (in some cases, the reference is to First Nations, Inuit and Métis).[22]

Women (17 projects) (See also: Aboriginal Population above).

- Ten (10) projects target government departments/agencies/service providers and organizations that work with women. [23]

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[17] Via knowledge building and dissemination for parents (at risk parents) and/or professionals and practitioners who work with children and youth.

[18] Two projects brought key players together (a Federal government round table, and a National Workshop on Seniors and Medication, Alcohol and Other Drugs). One project identified and assessed strategies for reaching at risk seniors. Four projects addressed the need to share information and knowledge amongst the players. Three projects resulted in the production of videos and/or guides for seniors.

[19] Three are public awareness campaigns/events/ads (including National Addictions Awareness Week). One is an inventory of substance abuse prevention programs.

[20] The development of a network of youth peer counsellors in Native Friendship Centres.

[21] Including a conference on health issues, and the consultation/development of a prevention program model

[22] Three projects deal with the development/training and evaluation of a Training Model for Community Development and Program Evaluation for Aboriginal peoples. One project consists of regular meetings with national Aboriginal organizations. Three involve advertising and promotional products for an Aboriginal audience. The last project is international: participation in the UN Expert Meeting on Aboriginal Peoples.

[23] Two projects deal with needs of rural women specifically. One project focuses on immigrant women's needs. Another deals with the needs of disabled women. Three projects brought key players together (federal round table, national workshop, and video based on workshop, and a teleconference). Two projects produced information on available resources/strategies. One project deals with the link between alcohol/other drug use and violence against young women.

- Five (5) programs target women directly.[24]
- One project targets home care workers (most of whom are women).[25]
- One project targets nurses (most of whom are women).[26]

DWI (Driving While Impaired) First and Repeat Offenders (4 projects)

- Four (4) projects deal with DWI issues/programs.[27]

Other Target Groups

- Fetal Alcohol Syndrome (FAS) (6 projects)[28]
- General population (1 project)[29]

The list of the regional Community Support Program projects were also analyzed. (Please note: reports from the CSP database may further clarify the relative weighting of projects for each at risk group in each region). The following is a summary of the preliminary analysis:

Atlantic Office

The main focus was on projects targeting either youth or out-of-the-mainstream youth. (In some cases, youth projects may in fact focus on populations of at risk youth.) The split appears to be about even, with approximately 13-15 projects for each target group. Women were the target for an additional 8 projects, while seniors were the focus of 6 projects. Aboriginal people were the target of about 8 projects (including 2 that specifically referred to the off-reserve population). Of these, youth, women and children in Aboriginal communities were specifically cited in some projects. There were

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[24] Media/communications/social marketing strategies, including magazine articles, private sector partnerships, t.v. shows, videos.

[25] Project focused on determining their info/education needs/issues.

[26] Providing support for nurses to seek help for themselves and others with alcohol/drug problems.

[27] Including an international literature review, an inventory of existing federal/provincial programs, an evaluation of Manitoba's Assessment and Rehabilitation Program for Convicted Drivers, and F/P/T discussion re: evaluation of DWI programs.

[28] CCSA received funding to respond to information needs of professionals, service providers, those with FAS, their families and the public. Other projects included the development of a Joint Statement on Alcohol and Pregnancy; An Analysis of Alcohol Related Mortality and Morbidity (this was part of the economic costs of substance abuse study; training, evaluation and dissemination of a Alcohol Risk Assessment and Intervention Project (ARAI) curriculum for physicians; the expansion of Operation Nez rouge chapters (alternatives to driving while impaired); and the development and testing of a national model to increase peoples control over their drinking and related problems (Drinking Decisions).

[29] 60 minute documentary on men's violence and the links with alcohol, other drugs and the effect on children and teens.

3 DWI related projects. There were 2 projects that appeared to target the general community. Family, children, immigrant/multicultural communities and FAS/Mentally Handicapped each had one project.

Quebec Office

There was a heavy emphasis on OOMY projects (38 projects targeted this population). Another 8 projects targeted youth in general (including one project focused on multicultural youth). Women were the target of 6 projects (including one project that targeted teen women). There were 3 DWI projects. Three projects targeted the general community. Seniors, Aboriginal people, children at risk and families at risk had one project each.

Ontario Office

The largest group of projects included 15 OOMY projects, and another 10 youth projects (including one related to lesbian/gay youth and one for Black/Caribbean youth). There were 11 DWI projects, including some focused on offenders. Ten (10) projects targeted off-reserve Aboriginal peoples, including three focused on children. Women were the target group for 7 projects. Seniors were the target for 4 projects. Eight (8) projects targeted the general community. Children/parents, families, FAS, addicts and prostitutes each had one project.

Manitoba/Saskatchewan Office

OOMY (8) and Youth (8) projects dominated. Aboriginal peoples were the target of four (4) projects (including one project targeting off-reserve children and youth). Women and DWI were each the target of three projects. Another three projects targeted the general population. A further three targeted FAS issues. Prostitutes were the target of one project. There were two projects devoted to coordination/networking/communications/strategic planning in the region.

Alberta/NWT Office

Projects targeting Aboriginal peoples (12) were the most numerous and included projects targeting Aboriginal women (3), off-reserve youth (4), Aboriginal youth & adults or general population (4) and Inuit youth (1). Seven (7) projects targeted at risk youth[30], plus 1 project focused on facilitators working with at risk youth. Five (5) projects targeted women, including female offenders. There was one project each for professionals working with at risk children, parents at risk, students and their families, and seniors. Two projects focused on street prostitutes, and two were DWI-oriented. One project listed does not specify a target group, but may be for at risk youth.

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[30] This may include OOMY projects.

BC/Yukon Office

OOMY (14) and Youth (10)(including one Latin American and one multi-ethnic project) projects were the main focus in this region. There were 12 projects focusing on Aboriginal peoples (including 5 specifically for off-reserve, including projects focused on children, youth at risk and fathers). One First Nations project focused on solvent abuse. There were 6 projects targeting women, including one multi-ethnocultural project. Five (5) projects targeted seniors, including one multi-ethnocultural project. Six projects targeted DWI, including four oriented towards first/repeat offenders. There were five projects focused on FAS, and two on families. Two projects targeted the general community (and could possibly be for off-reserve Aboriginal people). There were 8 community/regional level coordination/communications/planning projects in this region.

NHRDP

In order to develop a program of targeted research, NHRDP, in collaboration with HPD, revised their Request for Proposal to reflect the new target groups under Phase II.[31] The target groups listed in the RFP are identical to those identified in the HPD strategic planning document (listed above), with one exception: NHRDP described the Off-Reserve population group in a slightly different manner (i.e. they did not indicate that living off-reserve was part of the "in particular" note and they included both status and non-status Indian people):

- **Off-Reserve Aboriginal People**

In particular:
- Métis, Inuit, and Indian (status/non-status) people who may be particularly vulnerable to problems related to alcohol and/or other drugs.

Prior to the revised RFP, NHRDP held a national consultation with members of the extramural research community, non-governmental organizations, and federal and provincial representatives, which identified the following priority categories for targeted research: etiology, epidemiology, treatment and prevention.[32]

According to an MSB document, NHRDP redefined its priority areas to include the health of aboriginal peoples, but it is not clear whether or not this took place under CDS. [33]

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[31] Departmental personnel note that targeted research was also conducted under OADDI including research on youth and women.

[32] Departmental personnel note that target groups were identified within each of these four broad categories.

[33] NHRDP did announce a competition on diabetes research among Aboriginal people in January 1992. NHRDP provided over $1M in projects under this Initiative, and the amount was to increase following approval of projects reviewed in March 1994.

A list of projects funded was forthcoming at the time of this report.

MSB

According to the MC and TB Submission, it appears that programming targeting on-reserve communities[34] was already in place, making CDS programming a "continuation" of such programming. Therefore, targeting the on-reserve population under CDS does not represent a change in targeting. CDS was, however, to focus on-reserve programming towards on-reserve youth. It is not clear to what extent this has taken place (with the exception of one national level program which does target on-reserve youth). Off-reserve programming was implemented under CDS. This programming was to target off-reserve youth, and appears to have done so.

On-Reserve Component

The On-Reserve component consists of two areas of activity: 1) two projects coordinated by the national level, and 2) community funded programs for First Nations communities coordinated by the regional offices. The vast majority of the resources for the on-reserve component (1.1M out of a total allocation of 1.5M) went to the regional offices. The remaining .4M remained at the national level.

The programs to be coordinated by the regional level were to target: "youth in a variety of awareness and prevention activities".[35] According to the documents, "The funding is used for "community-level health promotion, prevention and education activities....Two-thirds of CDS funds dedicated to on-reserve programs have been used to support the design and implementation of health promotion, prevention and education activities for on-reserve status First Nation and Inuit youth at the community level. Regional offices of Medical Services Branch coordinate community funding. Sample projects have included the development of youth councils, leadership training, life skills development, peer counselling, community awareness projects, role model visits, and in-school projects. Often, these activities address cultural and linguistic issues." [36]

There were two projects coordinated at the national level: National Addictions Awareness Week and the National Native Role Model program. According to MSB personnel, the Native Role Model program was more targeted to youth than was National Addictions Awareness week.

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[34] According to an MSB document dated 11-10-93 on G's & C's Issues Clarification, MSB "considers that Inuit are "on-reserve" when they are in their communities. MSB considers the Yukon as part of their on-reserve responsibilities. MSB helps fund the Innu even though they are considered "off-reserve" since they are not governed by the *Indian Act*, but rather by a " Canada-Newfoundland Agreement."

[35] MSB (June 12, 1992) Memorandum to Regional Directors, MSB from DG, Indian and Northern Health Services.

[36] MSB (March 18, 1996) Advice for Minister.

National Native Role Model Program

Originally funded by NNADAP, the program used to have nationally known figures as role models. Under CDS, the program underwent an "extensive program review and has been recast as a means of promoting and supporting community values". Now it has switched to community-based role models who are nominated by youth (and sometimes are youth). The program has also expanded to the off-reserve population.

National Addictions Awareness Week

National Addictions Awareness Week activities now target off-reserve Aboriginal people as well as the on-reserve population.

Finally, it appears that one on-reserve project specifically targeted children in grades K to 8. [37]

Off-Reserve Component

In 1993, Health Canada held consultations with five national Aboriginal organizations to plan a national strategy related to solvent abuse. There was also a national youth consultation. A Working Group of representatives from AFN, NAFC, NCC and MNC was formed. The results of these consultations are in the report, "The Truth Heals".

The project lists provided by MSB indicate that the majority of resources ($500,000 to $750,000 out of the $IM allocation per year) were devoted to funding solvent abuse prevention projects at the community level (Note: A memo sent to the Regional directors regarding the on-reserve component mentions that the off-reserve component would have a "social marketing focus"). Virtually all funded projects were operated by Native Friendship Centres (and a handful of other off-reserve Aboriginal organizations). The projects appear to have been focused in the area of solvent abuse prevention. Given that solvent abuse is primarily a youth issue, it appears that these projects targeted youth (3 projects on the [38]95/96 list and 4 on the 94/95 list are explicit re: their focus on children, children and parents, or youth/teens). The total number of projects funded was 14 (96/97), 18 (95/96), and 9 (94/95).

The remaining resources were allocated to the Youth Peer Counselling in Friendship Centres project which received funding for 3 years, in conjunction with HPPB. This project targeted off-reserve Aboriginal youth.

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[37] Addictions curriculum package, "First Nations Freedom" distributed to all on-reserve schools.

[38] Research project on how substance abuse affects the Métis population.

Other activities of the off-reserve component targeted either off-reserve community groups[39]; the Métis population; or off-reserve children in grades K-8.[40]

HPB

The Mid-Term Review Report noted that HPB activities under CDS represent a continuation of previous activity, much of which is "immune" to changes in target group. According to Bureau of Drug Surveillance personnel, however, some programming has been targeted, but no details were available in the documents reviewed.

The Mid-Term Review Report also suggested that HPB's targeting of people who may be involved in multi-doctoring may not be cost-effective and that these resources may be better spent elsewhere.

Preliminary analysis and possible evaluation issues

HPPB

For activities undertaken and funded by the various players in HPPB, programming targets have definitely changed. Extensive work has been conducted, since the beginning of Phase II, to select specific at risk populations as target groups, and to research the needs and appropriate means of addressing the needs of these populations. Furthermore, pilot projects and extensive collaborations, both nationally and regionally[41], have resulted in the implementation of projects that directly address the needs identified.

At the same time, based on the project titles alone, it's not always possible to determine whether projects targeting youth, in fact targeted out-of-the-mainstream youth. For DWI projects, the majority of projects at the community level appear to have focused on prevention, with only a handful addressing first/repeat offenders.[42]

Possible Issue: *What is the relative balance of projects for each at risk group and why?*

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[39] Community Action Packs distributed to off-reserve groups as planning resource.

[40] Friendship Centres across Canada received the Mokakit curriculum, a First Nations-specific alcohol and drug abuse curriculum for grades K-8.

[41] According to Departmental personnel, this included collaborations at the provincial/territorial and community levels.

[42] Departmental personnel note that this is because, for practical reasons, offender programs have to be operated at the provincial rather than the community level.

Possible Issue:	*Did the targeting of at risk groups differ based on activity area, i.e. did social marketing, research, education and training, collaborative program/policy development,etc. each target every identified at risk group. If not, what were the reasons for this? Was this a question of strategic planning?* [43]
Possible Issue:	*What superseded education/training activities conducted in the schools?*[44]

NHRDP

Possible Issue:	*Did NHRDP fund projects targeting exclusively off-reserve Aboriginal people under CDS?*

MSB

According to MSB personnel, NNADAP was created in 1982 and is still functioning, but the focus of its treatment, prevention, research and training activities is on alcohol and on adults. The CDS, therefore, was an attempt to focus more on youth and on other substances. CDS was, in part, a recognition that solvent abuse and other substance abuse problems besides alcohol should be addressed, and that youth should be a specific focus for these activities.)

CDS is also an attempt to recognize that the expertise and treatment required to deal with solvent abuse is very different.

NNADAP funding is administered separate to CDS, but at the community level, there may often be one pool into which resources from NNADAP and CDS are combined. Although NNADAP and CDS are administered under different contribution agreements, communities may choose to utilize the resources from both programs to support a particular activity, eg. where CDS resources are low and insufficient to support a particular activity. Financial accounting, however, remains separate for each program.

There has also been money for solvent abuse (treatment, prevention, and research) in on-reserve communities that comes from Building Healthy Communities and Brighter Futures. Under Brighter Futures, there was a recognized need for more training for community workers to become aware of and deal with this issue.

There is some question as to the extent to which on-reserve funding has in fact been targeted to on-reserve youth. The decentralization within MSB means the regional offices do not submit reports to the national level concerning the types of projects funded. Personnel at the national level believe the funds have, in fact, been targeted to youth-oriented projects, but note that funds may well be combined with those of other initiatives and that project targets are primarily dictated by community determined needs and the available delivery infrastructure.

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[43] Departmental personnel have indicated that the dichotomy in targeting was basically between social marketing and other CDS components because of limitations in targeting high risk groups through social marketing activities.

[44] According to Departmental personnel, Phase I of CDS had made a range of resource items to schools (eg. education videos, lifeskills programs, etc.). Under Phase II, the focus was on ensuring continued use of existing resources.

Similarly, for off-reserve projects, delivery infrastructure is an important factor. Most of the projects are funded through aboriginal organizations that serve the general off-reserve population, rather than specific sub-groups.

In addition, the Mid-Term Review Report of Health Canada's CDS component suggested that MSB programs could be further targeted, presumably to focus on Aboriginal women, youth, seniors, and so on.

Possible Issue: *To what extent did off-reserve community-based projects funded under CDS target youth?*

Possible Issue: *To what extent did on-reserve community funded projects under CDS target youth?*

Possible Issue: *What is the impact of combining CDS and NNADAP funding at the regional level?*

Possible Issue: *To what extent have projects and grants and contributions for both on- and off-reserve aboriginal populations been further targeted to address the needs of other sub-groups of the Aboriginal population? How relevant/necessary/appropriate is this exercise?*

HPB

For much of HPB programming, targeting may not be relevant, e.g. services provided to enforcement officials are not targeted.

Possible Issue: *To what extent is targeting of HPB appropriate? To what extent has targeting taken place?*

Further action for evaluation

The interview questions will address targeting in Phase II CDS in depth, including relative emphasis on target groups, by activity area. In addition, the following steps will be taken:

HPPB

Within HPPB, the Community Support Program (National and Regional level grants and contributions funding) has a database of funded projects which apparently can produce reports on total number of projects and funding by target group in each region for each year of the CDS. A report on the Community Support projects funded by target group at the national and regional levels has been requested, and will be reviewed when it becomes available. Once obtained, this report will be used in the analysis of financial data, and to further assess the targeting of projects under the Community Support Program.

For other projects undertaken with HPPB, the activity profiles provided by the OADDI have been analyzed to generate a breakdown of approximate numbers of projects by target group. It was not possible to obtain more accurate data on projects by target group from financial administrative records.

NHRDP

A list of projects funded by target group has been requested. Once obtained, it will be used to determine the emphasis placed on each at risk population targeted.

MSB

Project lists provided for the off-reserve program component have been analyzed, and the results (noted above) will be further discussed in interviews with program personnel.

The regional offices of MSB may be contacted on an informal basis to determine whether or not information on projects by target group is maintained. Should this information be available, it will be reviewed and the results will be incorporated into subsequent reports.

HPB

The interviews will be used to discuss targeting of activities within HPB.

✓ *What was the basis for these changes?*

Evidence in documents

Targeting under Phase II, as articulated in the relevant CDS documents, are compared in Table I below.

TABLE 1: SPECIFIED AT RISK POPULATIONS & TARGET GROUPS FOR HC CDS ACTIVITIES

MC	TB Submission	HPD Strategic Planning Document
Street kids, Dropouts	At risk youth in schools and communities (primary and secondary prevention programs; drug education initiatives; Gs & Cs for prevention and treatment programs) Out of the mainstream youth (street kids, dropouts) (new targeted research on trends in alcohol and drugs use; NHRDP research on street kids; research on this group for targeted multi-media campaign; activities to include advertising, info and promo products, community resources and support, ongoing analysis) Young adult males (research for targeted multi-media campaign on dwi; activities to include advertising, info and promo products, community resources and support, ongoing analysis)	**Children, Youth and Young Adults** Particularly, -"out of the mainstream" youth such as school dropouts, the homeless, runaways and street youth, those in homes where family violence is occurring -those who need to develop coping skills or improve their self-esteem.
	Children (Gs & Cs for prevention and treatment programs) Children and Adolescents (first ever national survey in Canada on this group)	
Off-Reserve Aboriginal	Off-Reserve population (drug education initiatives focused on families, youth at risk; social marketing grants and contributions program including solvent -related info, health promo materials, media campaign & funding for community-based youth activities; NHRDP research).	**Off-Reserve Aboriginal People** Particularly, -Métis, Inuit and Indian people who are not living on a reserve and who have specific concerns related to alcohol and/or other drugs. Note: NHRDP Request for Proposals modified this to read: Métis, Inuit, and Indian (status/non-status) people who may be particularly vulnerable to problems related to alcohol and/or other drugs
	Youth in FN communities [On-Reserve] (addictions and community funnelled awareness and prevention programs)	
	Native people (new targeted research on trends in alcohol and drug use)	
Unemployed	Unemployed (NHRDP research)	

MC	TB Submission	HPD Strategic Planning Document
Street kids, Dropouts	At risk youth in schools and communities (primary and secondary prevention programs; drug education initiatives; Gs & Cs for prevention and treatment programs) Out of the mainstream youth (street kids, dropouts) (new targeted research on trends in alcohol and drugs use; NHRDP research on street kids; research on this group for targeted multi-media campaign; activities to include advertising, info and promo products, community resources and support, ongoing analysis) Young adult males (research for targeted multi-media campaign on dwi; activities to include advertising, info and promo products, community resources and support, ongoing analysis)	**Children, Youth and Young Adults** Particularly, -"out of the mainstream" youth such as school dropouts, the homeless, runaways and street youth, those in homes where family violence is occurring -those who need to develop coping skills or improve their self-esteem.
Seniors	Elderly (NHRDP research)	**Seniors** Particularly, -adults over 55 years of age who misuse prescription and/or non-prescription drugs, or alcohol, or combine drugs and alcohol.
Women	Women (new targeted research on trends in alcohol and drug use; NHRDP research; Gs & Cs for prevention and treatment programs) Middle-aged women (research for targeted multi-media campaign re: licit drug use; activities to include advertising, info and promo products, community resources and support, ongoing analysis)	**Women** Particularly, -those who misuse prescription and/or non-prescription drugs, or alcohol, or combine drugs and alcohol; -those who may use alcohol and/or other drugs during pregnancy.
Dysfunctional families	Families (Gs & Cs for prevention and treatment programs, esp. effects of fetal alcohol and violence)	
	First and subsequent DWI drivers (Gs & Cs for prevention and treatment programs)	**Persons who drive while under the influence of alcohol and/or other drugs** Particularly, -persons who have previously driven while impaired, and who are at risk of doing so again.

MC	TB Submission	HPD Strategic Planning Document
Street kids, Dropouts	At risk youth in schools and communities (primary and secondary prevention programs; drug education initiatives; Gs & Cs for prevention and treatment programs) Out of the mainstream youth (street kids, dropouts) (new targeted research on trends in alcohol and drugs use; NHRDP research on street kids; research on this group for targeted multi-media campaign; activities to include advertising, info and promo products, community resources and support, ongoing analysis) Young adult males (research for targeted multi-media campaign on dwi; activities to include advertising, info and promo products, community resources and support, ongoing analysis)	**Children, Youth and Young Adults** Particularly, -"out of the mainstream" youth such as school dropouts, the homeless, runaways and street youth, those in homes where family violence is occurring -those who need to develop coping skills or improve their self-esteem.
	Health care professionals (rehab, re-integration, early detection and intervention re: substance abuse problems; drug monitoring program for early detection; information for licensing bodies; multiyear study on psychoactive drug use among health professionals) Doctors (monitoring inappropriate prescriptions) Patients (monitoring multiple-doctoring)	
	Community oriented groups including educators, community health and social workers, family counsellors, hospitality industry, police serving youth and families at risk (community, family, school-based education and training programs and resources re: alcohol, drugs, dwi)	

The TB Submission also explicitly states that partnerships with the private sector (re: support for print and broadcast advertising, promotional materials (including print materials), media buys, sponsorships, seed money for community activities) are to be pursued.

HPPB

The strategic planning process within HPD refined the suggestions for target populations made in the MC (which appear to have been based on a national consultation conducted prior to the renewal of CDS in 1991) and led to the identification of five at risk populations (listed in Table 1 above under "HPD Strategic Planning Document"). The results were published in a strategic planning document by the Health Promotion Directorate.[45]

NHRDP

NHRDP appears to have adopted virtually the same target groups identified in the HPD strategic planning document.

MSB

The TB Submission indicated that, under Phase II, youth should be the target of both on and off-reserve Aboriginal programming. The Mid-Term Review Report suggested that MSB should consider further targeting of programs. The information package announcing the off-reserve funding, however, does not mention youth as a target group: ("off-reserve communities an/or individuals wishing to undertake solvent abuse prevention.") Under the general project eligibility criteria, however, the package does state that "National and regional priority areas established through consultation with representatives of the off-reserve Aboriginal solvent abuse field may, from time to time, designate certain target populations, geographic regions, or particular problems as high priority areas. Consequently, in terms of project selection, those proposals which deal with issues within designated priority areas are likely to be given first consideration." Furthermore, the general project eligibility criteria does include a description of Primary Prevention which states that "A solvent abuse program of primary prevention aims to reduce the effects of abusing by decreasing the possibility of solvent abuse and increasing the possibility of positive growth and development. Primary prevention programs usually involve public education, public policy changes and environmental organization. These programs are presented to as many people as possible but concentration is on those youth who have not yet used or experienced problems with solvents."

HPB

The MC and TB Submission did not specify that enforcement/control activities undertaken by Health Canada should be targeted to at risk populations. The understanding appears to have been that only prevention programming would be targeted. The Mid-Term Review Report noted that HPB prevention activities have traditionally targeted health professionals and that continued under Phase II. The report further notes that targeting is not appropriate for all HPB programming, but that HPB should consider targeting where appropriate.

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[45] Health Canada, Health Promotion Directorate (February 26, 1993). Canada's Drug Strategy Phase II Strategic Planning for 1993-1997.

✓ *How have changes to the programming targets impacted on how well programs have met their objectives?*

Evidence in documents

It is not clear what program objectives this question is referring to. Specific program objectives were not located in the document review, although they may exist, depending on how "program" is defined.[46] The Evaluation Framework (1992) identifies objectives for the Prevention Component and the Enforcement and Control Component. The status of these objectives will need to be clarified.[47]

Objectives of the Prevention Component[48]

1. To prevent under-age use, and prevent abuse of alcohol (i.e. risk avoidance and reduction of high risk use), and abuse of other drugs (includes solvent abuse) (i.e. illicit drug use or non medical use of licit drugs) by target groups and the general public, thereby preventing the harmful consequences of abuse.
2. To strengthen capacity of communities, and community based organizations to prevent or reduce problems associated with alcohol abuse and to prevent any use of illicit drugs.
3. Provide information, knowledge and advice to key intermediaries including health practitioners, non government organizations and other levels of government about illicit drugs for program and policy development, evaluation and preventive action.
4. To promote judicious use of psychoactive substances as prescribed by health professionals.

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[46] Departmental personnel have suggested that the objectives of program/activity areas may be stated in CDS activity profiles and activity reports.

[47] Departmental personnel have indicated that OADDI may not have agreed to these four objectives as stated in Health and Welfare Canada. Program Audit and Review Directorate (March, 1993) *Framework for Evaluating Canada's Drug Strategy, Phase II.*.

[48] Health and Welfare Canada. Program Audit and Review Directorate (March, 1993) *Framework for Evaluating Canada's Drug Strategy, Phase II.*. NOTE: This document also notes that "The Memorandum to Cabinet states that the objective of Canada's Drug Strategy is to reduce the harm to individuals, families, and communities caused by problem alcohol and other drug use. However, given that the Strategy is a supplement to existing drug programming, the evaluation regards its core objective as improving harm reduction. The other orders of objective are related to this basic objective as a means to an end."

Objectives of Enforcement and Control Component[49]

1. Reduce supply and availability of illicit drugs.
2. Reduce improper use of psychoactive substances.
3. Protect the public from health risks associated with mood altering preparations.
4. Protect athletes from unfair advantage in sporting events and youth from possible harmful side effects from use of banned substances or methods.

It appears that the targeting of CDS programming took place alongside the targeting of at risk groups by other HC Initiatives (i.e. OADDI personnel have noted that HC's youth focus was an attempt to deal, not just with substance abuse, but with lots of other related problems).[50]

In addition, the Mid-Term Review Report noted that shifting social marketing and community support programs away from a general population focus meant that in some poorer provinces there are no general population programs anymore (the richer provinces may have had more ability to continue them if they so desired).

Preliminary Analysis and Possible Evaluation Issues

Given that other areas of Health Canada were also targeting at risk groups and related problems at the same time, we will need to look at the context in which CDS Phase II adopted a targeted approach.

Possible Issue: *Did targeting result in increased opportunities for linkages with other Initiatives being undertaken by Health Canada? Is so, how did parallel targeting within Health Canada impact on programming?*

Possible Issue: *Impact of targeting on provincial programming for general population.*

Further Action for Evaluation

This question will be discussed in interviews.

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[49] Health and Welfare Canada. Program Audit and Review Directorate (March 1993) *Framework for Evaluating Canada's Drug Strategy, Phase II.* NOTE: This document also notes that "The Memorandum to Cabinet states that the objective of Canada's Drug Strategy is to reduce the harm to individuals, families, and communities caused by problem alcohol and other drug use. However, given that the Strategy is a supplement to existing drug programming, the evaluation regards its core objective as improving harm reduction. The other orders of objective are related to this basic objective as a means to an end."

[50] According to Departmental personnel, much of the holistic approach to youth was how OADDI responded in their initiatives based on the inter-relationship of problems.

Improved Coordination and Cooperation

✓ How did the CDS improve coordination and cooperation within Health Canada, and between Health Canada and other departments?

Evidence in the documents

The Mid-Term Review Report notes that Health Canada officials did not know what coordination activities or outcomes were expected, i.e. were they to improve coordination between Branches, coordination within programs, coordination between programs and partners, and/or coordination between HC and other departments? (TB apparently said it was up to Health Canada to set such goals, while CDSS indicated that it lacked direction in this regard from TB.) The Mid-Term Review Report points out that examples of coordination did take place, but it is difficult to tell whether or not these things would have happened regardless of CDS.[51] The Mid-Term Review Report deemed that coordination was "weaker than it need be" because no goals/plan were put in place for the Initiative or for HC.

The Mid-Term Review Report identified the following examples of coordination:

Program-specific coordination

- relationships and informal partnerships between Government and NG0s under the Community Support Program
- relationships and informal partnerships between Government and NGOs under the Health Programs Support Division of MSB
- HPB coordination of drug analysis activities with law enforcement agencies

This type of coordination, according to the Mid-Term Review Report, is just good management and can't be linked to the existence of CDS. We note that the existence of these programs was dependent on CDS Phase II funding. Whether or not inter-branch coordination would have existed without CDS Phase II funding will be addressed in our interviews.

Inter-program coordination

The Mid-Term Review Report noted that CDS consisted of a set of individual and autonomous programs linked only by a common MC. The report suggests that this is not enough. The coordination within HPD is noted, including its collaboration with CDSS.

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[51] Departmental personnel suggest that activities under CDS were such that it was evident that coordination between all the players was a requirement in order that activities be effective. They also note that coordination was not a goal in isolation from programming, as the Mid-Term Review Report seems to suggest (i.e. it was a means not an end in itself).

Federal-Provincial coordination

The Mid-Term Review Report noted that there is no organization responsible for federal-provincial coordination of the CDS (the Federal-Provincial Advisory Committee on Alcohol and Other Drugs Problems was dissolved in 1990.) [52] The CDSS did see this as its role. Apparently, the Advisory Committee on Population Health had not raised this issue, despite being theoretically responsible for it. The report notes that OADDI had brought federal and provincial players to two meetings between the onset of Phase II and the time of the Mid-Term Review Report, but deems these efforts to be limited to discussion of research and prevention activities, i.e. information sharing, rather than the needed formal coordination.

Coordination related to enhancing the information base

The Mid-Term Review Report cites NHRDP's consultation meeting to discuss research priorities prior to revising its RFP.[53] The report notes that NHRDP did not, however, make suggestions about what research would be useful, and there were only a limited number of responses, mostly from universities, to the RFP. The report criticizes NHRDP for not better coordinating the research needs of CDS with the research community, and not communicating those needs to researchers, or ensuring that their products are used for policy and program development.

Inter-Branch Coordination

The Mid-Term Review Report noted that no organization exists in HC to coordinate HC programs in different Branches, and there is little inter-Branch coordination (except for HPPB/MSB).

The Mid-Term Review Report noted that HPB remained rather "isolated" under CDS, and that lack of HPB coordination may be a problem, e.g. in terms of general information-sharing and the drafting of Bill C-7. The report notes that one of the underlying premises of CDS was that better coordination between supply and demand side activities would be beneficial. The report also notes that although HPB has lots of information on psychoactive drugs, this information is not used outside the Branch for program/policy development.

HPPB played a role in proposal selection of MSB's off-reserve projects. HPPB collaborated with MSB to develop their off-reserve programming in the areas of public awareness, policy development, research and evaluation, and the Community Support

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[52] Departmental personnel note that there is a presupposition here that coordination requires a formal organization for this purpose. They indicate that a lot of informal coordination took place to ensure that programming was as effective as possible.

[53] Departmental personnel note that a wide range of research ideas (and their relative importance)were discussed at this meeting.

Program. Departmental personnel have indicated that Policy Consultation Branch was also involved with coordination with other HC branches regarding alcohol issues, including FAS, warning labels, and issues related to CRTC advertising.

The Mid-Term Review Report suggested the following areas of possible coordination:

- coordination re: decisions regarding what research each Branch will conduct to prevent duplication
- coordination of information between Branches on what prevention works best for populations using psychoactive substances
- joint demand reduction program design (and possibly control programming, too)
- coordination of policy development (if review of drug policy takes place after passage of Bill C-7, this would help)[54]

Coordination between Health Canada and other Departments

The Mid-Term Review Report suggests that, in the absence of a plan, the CDS represented only linked activities, many of which predate the Strategy. It suggests that most activities would have existed in the absence of the CDS, e.g. HPB drug analysis services for police. It makes the following observations about Health Canada's coordination with other departments:

- coordination with other departments on Anti-Drug Profiteering Units was limited to drug analysis activities, and HPB did not get much involved in evaluation, coordination of the Units.
- at the time of the mid-term review, the CDS Interdepartmental Committee had not met for many months. Its purpose appeared limited to information sharing and there was limited participation from departmental representatives attending meetings
- only in late 1994 was the mandate of the ADM Steering Committee on CDS expanded beyond evaluation to include "steering the Strategy itself".

CDS Secretariat

The Mid-Term Review Report made the following observations about the CDSS and its role vis-a-vis coordination within HC.

- responsibility for coordination within HC was always unclear, therefore a lot of confusion ensued, e.g. confusion between role of CDSS and CCSA
- CDSS held a series of bi-lateral meetings with members of IDC to determine CDSS role, but no clear direction resulted

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[54] Departmental personnel have questioned the relevancy of these suggestions.

- many HC officials saw CDSS as only having a role interdepartmentally re: policy coordination NOT programming.
- some HC officials considered CDSS to be more concerned with law enforcement than health issues.

The report also comments on CDSS's interdepartmental coordination role:

- outside HC, CDSS was seen as a HC institution with little relevance for other departments
- location of CDSS within HC may have been a problem at the interdepartmental level
- moving CDSS into a line Branch may have impacted on its ability to be seen as acting on behalf of the entire Strategy.
- final evaluation should look at how the organizational changes (moves) affected CDSS' ability to coordinate on an interdepartmental level.

The Mid-Term Review Report noted that CDSS did engage in some coordination activities within Health Canada, particularly related to policy development. These activities included organizing a workshop on OOMY, drafting of departmental position paper on Harm Reduction, and policy work related to Bill C-7 (i.e. they helped in facilitate the development of a departmental consensus re: legislation and policy implications).

Apparently, CDSS was "less proactive" in terms of coordinating within HC at the program level. HC officials did not want CDSS to play a program role.[55] They believed the CDSS role was at the interdepartmental level.

The report concludes that CDSS had little success coordinating at the program level either within HC or interdepartmentally.

Ultimately, the CDSS played a role as the "conscience" of the CDS, and were limited to reminding participants of overall objectives of CDS, and of the larger whole.

Coordination Infrastructure

The document review revealed that CDS Phase II has, in fact, resulted in the formation, continuation and/or revitalization of a series of formal mechanisms for both national, F/P/T, interdepartmental, departmental, and Branch level coordination and collaboration.

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[55] Departmental personnel note that CDSS had made it clear that they did not have sufficient staff to do programming and that it was not part of their role.

Preliminary Analysis and Possible Evaluation Issues

Clearly, CDS Phase II did, in fact, lead directly to the establishment of a series of formal coordination mechanisms. But the establishment of these mechanisms, of itself, indicate that effective coordination and collaboration took place. Furthermore, according to Departmental personnel, Departmental coordination within HC has been conducted at the interdepartmental level, with the exception of departmental meetings regarding specific issues such as drug policy.

Possible Issue:	*To what extent did the formal coordination/collaboration infrastructure launched and/or continued under CDS actually improve coordination and collaboration at all levels?*
Possible Issue:	*There is an infrastructure for federal funding of substance abuse treatment and prevention in on and off-reserve Aboriginal communities which has included CDS funding as well as other funding under separate Initiatives (eg. Brighter Futures, Building Healthy Communities). How has the existence of different sources of substance abuse funding impacted on coordination under CDS Phase II?*
Possible Issue:	*Where is the most valued added from coordination? Where is coordination needed? Is there a need for both a Departmental CDS committee and an interdepartmental CDS committee or would this create unnecessary overlap, i.e. it may only be necessary in areas of shared programming within the Department.*

Further Action for Evaluation

The interviews will clarify what has taken place since the mid-term review, flesh out the accomplishments of the formal infrastructure, identify non-documented instances of coordination/collaboration, and explore the issue of what was needed vs. what was done in the area of coordination/collaboration.

✓ *What action was taken to improve coordination and cooperation?*

Evidence in the documents

We collected a lengthy list of formal coordination/collaboration mechanisms. OADDI personnel have reviewed the list and provided preliminary information about these mechanisms. Many of these bodies were created under Phase II CDS. These mechanisms include national bodies involving governmental and non-governmental players; federal/provincial/territorial bodies involving government representatives at all levels; interdepartmental mechanisms involving representatives of all CDS partners; departmental level bodies involving CDS component representatives and other relevant departmental personnel; and Branch level mechanisms involving CDS personnel and others involved in related areas of activity. The list is contained in Appendix B.

National

Three of the national level mechanisms appear to have emerged as a result of at risk population targeting. Improving national level collaboration and partnership building was the purpose of the National Steering Committee on Out-of-the-Mainstream Youth (OOMY), the Networking Group on Women and Substance Abuse Prevention, and the Street Lifestyle Working Group, all of which were created under CDS Phase II. Two other national level mechanisms are sponsored by CCSA and relate to FAS and other policy issue areas, as well as media-related issues (see Appendix B).

Personnel from either CCSA or HPPB are cited as participating in these forums. It is not clear to what extent representatives of MSB or HPB CDS components were involved. According to Departmental personnel, MSB representatives became involved in whenever there was an Aboriginal component to work undertaken by these mechanisms, while HPB became involved only when the work involved a medication aspect (eg. seniors and medication workshop).[56]

F/P/T

The three levels of government appear to have used three formal F/P/T mechanisms to coordinate/collaborate in the area of Seniors and Medication, DWI, and Alcohol and Other Drugs issues. The Seniors and Medication forum was created during CDS Phase II, the other two appear to pre-date Phase II but, according to Departmental personnel, had new mandates and leadership under CDS Phase II.

Representatives of HPD are cited as participating in these forums. It is not clear to what extent MSB or HPB CDS components were represented.

The Mid-Term Review Report noted that a big gap in coordination at the F/P/T level was created by the disbanding of the Federal/Provincial Advisory Committee on Alcohol and Other Drug Problems.[57]

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[56] Departmental personnel note that the Health Enforcement in Partnership Steering Committee was another mechanism.

[57] According to Departmental personnel, in 1994, an F/P/T group decided to continue to meet and, in an informal way, serve the same coordination purpose as the earlier Advisory Committee.

Interdepartmental

The main coordination mechanism for the federal government's CDS initiative was the CDS Interdepartmental Working Group (a.k.a. CDS Interdepartmental Committee), which was "reactivated" under Phase II.

The CDS Interdepartmental Committee appears to have been at its most active in 1994, with no record of any meetings in 1995 or 1996 (this may be related to the fact that CDSS changed form in 1995 and ceased to exist in 1996 - see CDSS below).[58]

The ADM Steering Committee was originally mandated to deal solely with the evaluation of CDS. In 1994, it expanded its mandate to address substantive issues concerning the management of CDS and preparation for renewal in 1997. The Committee appears to have met five times (once in December 1992, three times in 1994 and one meeting in 1996). The second last meeting in December 1994 dealt with future planning in light of the sunsetting of CDS in March 1997. The minutes suggest that a renewal committee was being created by CDSS and national consultations were being considered at that time. This meeting also considered a proposal to develop a national plan regarding substance abuse which could take effect after CDS. According to Departmental personnel, the ADM Steering Committee then met again in June 1996 and re-established the Interdepartmental Working Group.[59]

The interdepartmental CDS Communications Working Committee was created by CDSS under Phase II. Health Canada also led the Interdepartmental Committee on Bill C-8.

Health Canada CDS representatives also appear to have participated in several other interdepartmental coordination mechanisms, led by other departments, including the:

- Interdepartmental Committee on International Drug Issues (led by FAIT, pre-dates CDS Phase II),
- Interdepartmental Committee on DWI (led by Justice, new leadership and mandate under CDS Phase II), and
- Interdepartmental Committee on Transnational Organized Crime

Personnel from CDS Secretariat and HPD appear to have been involved in each of these forums. It is not clear from the documents to what extent representatives of MSB and HPB CDS component participated in these forums.

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[58] This is based on the files reviewed and is to be confirmed by Departmental personnel.

[59] Departmental personnel note that no meetings were held between December 1994 and June 1996 because of the uncertainty of funding until the budget announcement in 1996.

Departmental

Formal Departmental level coordination mechanisms were created to deal with Bill C-7, as well as FAS, Alcohol and Seniors and Medication (see Appendix B).[60] The FAS Coordinating Committee and the Seniors and Medication Working Group were created in Phase II.

Personnel from HPPB appear to have been involved in each of these forums. It is not clear to what extent representatives of MSB or HPB participated in these mechanisms. Departmental personnel have indicated that all three Branches were involved in each of these mechanisms.

Branch (HPSB, now HPPB)

Branch level mechanisms were established during Phase II. The CDS Resource Group was set up to conduct integrated program planning, information sharing and resource allocation within the Branch.

The Mid-Term Review Report noted that it was in this Branch that most of the coordination under CDS took place. The report cites the CDS Resource Group, as well as collaborative initiatives between this Branch and MSB regarding programming for off-reserve Aboriginal.

Role of CDS Secretariat

It appears that the mid-term review did not look at CDSS activities "beyond the borders" of Health Canada, i.e. at its interdepartmental and international role in coordinating CDS. The Mid-Term Review Report deals primarily with CDSS performance re: Health Canada's programming. It does, however, consider this in terms of all the areas CDSS was mandated to do (i.e. not just coordination, but communications, data collection and evaluation).

The paper trail for CDSS activities is very sketchy, particularly after 1994. A timeline report (August 1994) indicates that the CDSS had planned, in 1995, to engage in activities related to evaluation of CDS (i.e. Revision of Mid-Term Review Report, TB report) and a process on consultation and renewal of CDS (i.e. obtaining approval of CDS Interdepartmental Committee, testing the waters, creating a consultation plan). In 1996, it appears that CDSS was expecting to begin the final consultation process, produce a consultation report and an Aide Memoire, and draft an MC requesting renewal in 1997.[61]

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[60] Departmental personnel note that departmental level coordination also took place regarding OOMY, Women and Off-Reserve Aboriginal.

According to OADDI personnel, the CDSS became the Office of CDS in the Spring of 1995, and the Office ceased to exist as of April 1996.

On March 7, 1996, a memo from CDSS to members of the CDS Interdepartmental Committee indicates that activities under CDS will be reduced in order "to provide a stable funding base for a Population Health Strategy". It is not clear whether this refers to CDS Secretariat or to Health Canada. In addition, it states that the "more extensive coordination activities of the former Canada's Drug Strategy Secretariat will no longer be carried out." The memo indicates that commitments under CDS will be continued, but no new projects will be undertaken. As well, the memo mentions plans to continue working in the area of substance abuse. It is not clear whether the memo refers to HPPB or Health Canada.

Concerns re: CDSS role in Coordination noted in Mid-Term Review Report

The Mid-Term Review Report noted that the CDSS coordination role may have been hampered by the following problems:

- no coordination goals established by/for CDSS
- limited acceptance of CDSS coordination role in HC and other departments
- CDSS location in HPSB
- confusion re: roles of CCSA and CDSS.

CDSS's coordination "accomplishments" noted by the Mid-Term Review Report include conference/workshops on out-of-the-mainstream youth, HC position paper on harm reduction, and policy work re: Bill C-7.[62]

Role of CDSS in CDS coordination

The files do contain important background information on CDSS's role re: coordination under CDS. It appears that CDSS was mandated to perform interdepartmental coordination, but no mention is made of departmental coordination. Coordination itself is not defined as being either policy or program oriented.

An undated briefing note on CDS Secretariat says that the Secretariat's "primary role is to ensure the corporate functioning of the CDS across all federal partner departments....has responsibility for overall coordination of the CDS...and for coordinating such Strategy-wide functions as data development and evaluation." It details the coordination function as follows:

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[61] According to Departmental personnel, because of eminent funding cuts, CDSS cancelled the renewal activities.

[62] Departmental personnel note that other papers on Cannabis and Emergency Room Study were completed after the mid-term review.

"The CDS Secretariat is responsible for overall coordination of the federal strategy and provides a national focus and a link for the Strategy within the federal government, among governments and with other partners as listed above. It serves as a contact point for information on CDS (programs, initiatives by department/agency, and other partners). The Secretariat ensures that Strategy related initiatives and programs in federal departments are consistent with the direction, emphasis and target groups identified by the Strategy. In keeping with this role, the Secretariat also may identify a need for programmatic activity and bring appropriate partners together for discussion and appropriate response. As part of an ongoing process the Secretariat maintains a current knowledge base with respect to important developments within and outside the federal government related to substance abuse. The Secretariat encourages and participates in information collection and exchange among the CDS participants.

In a memo dated November 1992, just after the first meeting of the CDS Interdepartmental Committee following the renewal of CDS for Phase II, the CDSS makes it clear that the IDC will use the Committee as "a vehicle for enhanced communication, coordination and networking among federal partner departments involved in Canada's Drug Strategy."

The CDSS files also contain a set of undated workplans (which appear most likely to be for FY 93/94 and 94/95), the status of which is not clear (i.e. there are some marked "deleted", and very few appear to be fully completed in terms of milestones, responsibility and cost breakdown, suggesting they may not have been fully adopted. They do provide, however, some sense of how the CDSS envisioned its role. In these workplans, CDS Secretariat adopted Coordination as a "Priority Area" (the other priority areas are Policy Development, Communications and Visibility, Evaluation and Management).

The workplans state two explicit goals for the coordination area, including:

1) To facilitate and coordinate the implementation of CDS according to the MC. (One workplan says "To *promote* and coordinate the implementation of CDS according to the MC.)

2) To fulfil established international responsibilities of CDSS.

Projects related to these goals are listed in Appendix C.

Another workplan (which appears to be dated August 22, 1994) does not classify projects into the priority areas mentioned above.

It appears that, in late 1993, the CDSS consulted with all of the HC CDS component areas (and possibly other partner departments) on the optimal role for CDS Secretariat within the Initiative. In January of 1994, CDSS distributed a summary of the comments/questions raised about CDSS's role, and later indicated that it was planning to respond with a series of papers on each priority area of activity including coordination (these were to be completed by the end of 1994). Coordination is the area that appears to have generated the most comments/questions. It is not clear what the final outcome of these consultations was.

In addition, CDSS appears to have attempted to initiate the process of preparing for a federal government substance abuse policy review (which will take place October 96-June 1997, as announced in June 1996), as well as proposed preparations (i.e. national consultation process) for third-term renewal of CDS (this was not pursued).

An attempt was also made to have all MSB material and correspondence related to substance abuse copied to HPSB via the CDS Secretariat. The CDS Secretariat also pursued full representation from all HC CDS components at the interdepartmental level.

Interdepartmentally, CDS Secretariat coordinated the ADMs Steering Committee on CDS, as well as the CDS Interdepartmental Working Group.

Health Canada personnel also participated in a significant range of international level activities via an the Interdepartmental Committee on International (Narcotic) Drug Issues, led by FAIT. [63]

Preliminary Analysis and Possible Evaluation Issues

The actions taken to improve coordination and collaboration with reference to at risk populations were necessary steps to meeting program objectives, given the complexities of the issues/needs of these populations; the need to access the expertise both internal and external to the federal government, and, the need to share information on an ongoing basis to aid in the development of programs/strategies for these populations. Coordination and collaboration was also integrally linked to the partnership-building process, and to employing as inclusive an approach as possible to meeting the needs of at risk populations. Examples include the Networking Group on Women and Substance Abuse Prevention, and the series of national meetings with national Aboriginal organizations, among others.

There are examples of how coordination mechanisms averted the possibility of overlapping actions by various Health Canada or other departmental components of CDS, e.g. collaboration between OADDI and MSB in the area of programming for off-reserve Aboriginal populations.

Formal interdepartmental coordinating activities (namely the CDS Interdepartmental Working Group and the ADMs Steering Committee on CDS) have tailed off significantly since 1994, with a lessening of activity in 1995. There was only one meeting of the ADM Steering Committee in 1996.[64] The interviews will examine why interdepartmental coordination activities appear to have tailed off.

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[63] Departmental personnel note that Health Canada also participated in CICAD and was the lead department for the Commission on Narcotic Drugs.

Significant amounts of coordination and collaboration have taken place concerning specific at risk populations.

Possible Issue: *How was coordination envisioned and operationally defined for this Initiative? Involving what types of activities (policy, program), and at what levels?*

Possible Issue: *The impact of the mid-term review on subsequent coordination efforts.*

Possible Issue: *The impact of the decision not to renew CDS on coordination efforts.*

Possible Issue: *To what extent did each Branch participate on the CDS Interdepartmental Committee? (It appears that HPB may have initially withdrawn from the Committee in October 1993)*

Possible Issue: *Role of CDSS in coordination since the time of the mid-term review.*

Further Action for Evaluation

The interviews will focus on the value added of coordination mechanisms established under Phase II CDS. There will also be an opportunity to identify what coordination/collaboration may be ongoing, despite the decision not to renew CDS.

✓ *How have actions to improve coordination and cooperation impacted on how well programs have met their objectives?*

Evidence in documents

N/A

Preliminary Analysis and Possible Evaluation Issues

N/A

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[64] Departmental personnel note that the ADM Steering Committee was only supposed to meet once or twice each year, and that the Working Group was to meet more often.

Further Action for Evaluation

Questions about the impact of coordination mechanisms on achieving program objectives will be further explored in interviews.

Improved Information Base*

**Please see also the Report on CDS database activities in Appendix F.*

✓ *How did Health Canada intend to improve its information base?*

The TB Submission outlines the following information development activities:

Education and Prevention

Develop/Exchange information and materials

- conduct research for targeted multi-media campaign (young adult males re: driving while impaired, middle-aged women re: licit drug use, and out-of-the-mainstream youth (street kids, dropouts). Activities to include advertising, information and promotion products, community resources and support, ongoing analysis.

- partnerships with private sector re: support for print and broadcast advertising, promotional materials (including print materials), media buys, sponsorships, seed money for community activities

According to the Mid-Term Review Report, the following areas of Health Canada received funds specifically for information base activities: CDSS, NHRDP, CADS and CCSA. It appears, however, that other responsibility centres also conducted information development activities, including OADDI, Programs Promotion, MSB and HPB.

Information and Research

Targeted research on trends in alcohol and drug use with special attention to high risk groups. New research will focus on youth (including street kids and drop outs), women, Native people

- second national survey to focus on high risk groups, and include drinking and driving

- national survey on children and adolescents (first ever in Canada)

- Interdepartmental Study on Runaways and Street Youth

- review of evaluations of prevention and treatment programs for alcohol and other drugs

- revision of departmental publications (Alcohol in Canada and Licit and Illicit Drugs in Canada

Better prepared research teams to identify, synthesize and analyze new designer drugs

NHRDP to support research on target populations, and which reflects information needs of department

- research on target groups, including unemployed, street kids, elderly, women, off-reserve aboriginal people

- development of consensus on terminology

- data collection on patients and standards used in evaluation

- meta-analysis of existing databanks (Health Promotion Survey, National Alcohol and Other Drugs Survey, etc.)

- research in priority areas including Health Care, Health Promotion, Illness Prevention, Rehabilitation, Risk Management, Health of Aboriginal Peoples, and Dissemination of Health Research Outcomes

- support for research teams or units vs. individuals, isolated research

✓ What improvements have been made to Health Canada's information base?

Evidence in documents

HPPB

Based on activity profiles provided by OADDI, the following is a preliminary list of projects which served to enhance the HC information/data base re: substance abuse:

- Canada's Alcohol and Other Drugs Survey, including implementation of survey in NWT and at risk population study in Yukon.

- A study of resiliency in communities.

- Analysis of questions included on Cycle 8 of StatsCan GSS (results incorporated into Horizons)

- Supplementary questions re: alcohol and FAS on National Population Health Survey in 1994[65]

- Baseline Report - Alcohol, Licit and Illicit Drugs/ Horizons 1994: Alcohol and Other Drug Use in Canada. Horizons updated information in the original 1989 reports and included new information from GSS.

- Study of Links between Mental Health and Substance Use

- Examination of mechanisms for synthesizing and disseminating information on substance abuse.

- Coordination and facilitation of local information (qualitative and quantitative) on substance abuse in communities (Canadian Community Epidemiology Network on Drug Use)

- Costs of Substance Abuse in Canada - Report

- Literature Reviews and Guidelines for Research on At Risk Populations

- Identification of the nature and extent of collaborative efforts between health and enforcement areas across Canada.

- Federal round table on substance abuse.

- Evaluation of the Reparenting Program model developed by AFM Manitoba.

- Additional projects related to specific target groups, as outlined above in Targeting section.[66]

Training Projects (i.e. Knowledge Development and Dissemination)

- Four (4) projects either developed materials, evaluated training models' effectiveness, or conducted training needs assessments for professionals (including health care professionals and workplace personnel), practitioners, service providers in various fields.

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[65] Departmental personnel indicate that these questions referred to Alcohol, Medication and Illicit Drug Use During Pregnancy.

[66] Departmental personnel note that other projects included a Street Lifestyle Study and a Literature Review on the Characteristics of Repeat DWI offenders.

- Additional project targeting Aboriginal peoples, as outlined in section on Targeting above.[67]

CCSA activities in the areas of research and information are so extensive that they appear to have been the primary and most prolific vehicle for information development/enhancement/dissemination under CDS. In its Annual Review 1994/95, CCSA states that it sees its mandate to contribute "to the development and application of knowledge and expertise" in the substance abuse field as its "main raison d'être".

It cites the following activities as part of its goal to develop a "Canadian knowledge system on alcohol and other drugs":

- establishment of the National Clearinghouse on Substance Abuse
- study on estimating the social and economic costs of alcohol and other drug abuse (Costs of Substance Abuse in Canada was recently released)
- the Canadian Community Epidemiology Network on Drug Abuse (CCENDU), and
- the Workplace Substance Abuse Information Network.

Other information related services and activities include, among others: the Canadian Substance Abuse Information Network, the CCSA collection, special interest networks, electronic database products, print products and publishing, media relations, teaching and training and program and policy advice. CCSA also publishes Action News, a newsletter covering the substance abuse field in Canada and internationally.

NHRDP

A list of projects funded under CDS is still forthcoming at the time of this report.

MSB

Medical Services Branch, in collaboration with national Aboriginal organizations, developed a National Strategy on Solvent Abuse. The preparations for the Strategy captured information and expertise on this issue:

- The Truth Heals report summarizes the outcome of the consultations on the Strategy, identifies characteristics of solvent abusers, the contributing risk factors, and approaches to prevention that form the basis for the Strategy.

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[67] According to Departmental personnel, training projects also included a series of Russell Workshops on Working with OOMY.

HPB

- Enhancements to BDD information system.
- Study of Drug Use Among Canadian Professionals.
- National Workshop on Methadone Treatment.

The Mid-Term Review Report pointed out that there was no assessment ever conducted for Health Canada's data needs, and a plan for integrating "the production and use of information to the objectives of CDS". In addition, the review suggested that the following items were needed to manage information development:

- a coordinated understanding of what information is needed by HC for developing policy and legislation, for designing and delivering programs
- a coordinated plan for producing this information for the Department, not just on a program by program basis
- a way to ensure that the results of the data collection and analysis are usable by decision makers, and
- a way to facilitate the profitable use of this information by those who make decisions.

The Mid-Term Review Report suggested that there was little evidence that the information produced under CDS was used by Health Canada, although there were some good examples of information exchange (including forums for information exchange such as committees) between areas of Health Canada within and external to the CDS.

Preliminary analysis and possible evaluation issues

One of the most significant improvements in the information base appears to be linked to the targeting exercise. In order to target policy and programs, HC had to conduct research and consultation to determine the characteristics and needs of target populations. This, in itself, has contributed to the foundations of substance abuse programming and policy development in Canada.

There have been other, very significant, improvements to the information base, including, for example, the determination of the socioeconomic costs of substance abuse in Canadian society, among other activities.

It is important to note that enhancement of the information base was not limited to database activities but has included research and a host of other information development activities. The most active player in this regard has been CCSA's clearinghouse function. As well, according to Departmental personnel, HC has conducted all special surveys and participated on all CCSA steering committees.

Further Action for Evaluation

Interviews and the Literature Review will further examine how CDS information base enhancements have impacted on substance abuse programming and policy development.

✓ *How has Health Canada used the information that benefited from the CDS?*

Evidence in documents

This information was not provided in the documents reviewed.

Preliminary Analysis and Possible Evaluation Issues

N/A

Further Action for Evaluation

The interviews will be an opportunity to discuss this question in depth.

✓ *What effect has this information had on programming?*

Evidence in documents

Targeting of prevention programming appears to have been based on information on target populations developed under CDS Phase II. Furthermore, information development on target populations appears to have been ongoing.

Preliminary Analysis and Possible Evaluation Issues

The extent of integration between information developed under CDS Phase II and programming under Phase II may depend on the target population in question, the information products/mechanisms used, and the relative timing of information development activities/program development activities. The extent to which enhanced information has driven policy and program development may be limited by the fact that information enhancement activities began at the same time policy and program development was supposed to begin

Possible Issue: *What stage of integration has been reached - do we now have better information, just as the CDS sunsets? Is there much chance the information we've gained will continue to be used?*

Utilization of Resources

- ✓ ***What increase in resources was Health Canada to receive from CDS?***
- ✓ ***What resources did Health Canada actually receive from CDS?***

At its inception in 1992, the Health and Welfare component of the CDS was to receive a total of $191,350,000 over the period from 1992/93 to 1996/97. Starting in 1993, these funds were reduced as a result of reductions in Grants and Contributions and other budget cuts. Table 2 below shows the variance between the funds originally allocated to the CDS, and those that were finally available in each year of the Initiative.

TABLE 2: CDS RESOURCES

	92/93	93/94	94/95	95/96	96/97	TOTAL
Approved 1992						
Health Serv. & Promotion	13.4	17.9	17.9	16.4	16.4	82
Health Protection	0.17	2.37	2.37	2.37	2.37	9.65
Medical Services	2.5	2.5	2.5	2.5	2.5	12.5
Policy Planning & Info.	1	1	1	1	1	5
TOTAL	17.07	23.77	23.77	22.27	22.27	109.15
Actual (92-96) & Current budget (96-97)						
Health Serv. & Promotion	13.4	15.5	14.7	12.5	3.2	59.2
Health Protection	0.17	1.2	0.8	0.4	0.17	2.74
Medical Services	2.5	2.5	2.5	2.5	2.5	12.5
Secretariat	0.6	0.6	0.9	0.6		2.7
TOTAL	16.67	19.8	18.9	16	5.87	77.14
Variances:						
Health Serv. & Promotion	0	2.5	3.2	3.9	13.2	22.8
Health Protection	0	1.17	1.57	1.97	2.2	6.91
Medical Services	0	0	0	0	0	0
Secretariat	0.4	0.4	0.1	0.4	1	2.3
TOTAL VARIANCE	0.4	3.97	4.87	6.27	16.4	32.01

We do not believe it would add significant value to this evaluation to try to reconstruct the details of the various budget cuts that resulted in the allocation shown above. It is noteworthy however that, from an original allocation of $22.3M slated for 1996/97, the funding level had dropped by $16.4M[68] to $5.9M.

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[68] Note: the Secretariat was disbanded at the end of 1996.

Specific projects were targeted[69] to specific target populations primarily within the Health Promotion and Programs Branch. The Medical Services Branch targets only Aboriginal people, on and off-reserve, primarily youth (although at least Alberta Region also targets seniors). The Health Protection Branch did not identify its activities according to target groups.

We developed Table 3 below from a number of sources, including project descriptions and yearly workplans. We were unable to obtain definitive data from the Programs on project targeting, because none maintain an electronic database from which targeting data could be extracted. We did not attempt to reconstruct the targeting for all the activities undertaken by the Programs over the last five years. Rather we reviewed a sample of project descriptions and workplans representing 16% of CDS HC funds. Over 90% of those projects were targeted to specific populations. Within that sample:

- Youth were the primary target of the HC projects (43.9% of funds)
- Aboriginal groups, women and seniors each got between 16%-21% of project funds (not including the funds allocated to Medical Services Branch).
- DWI projects were not a high priority, representing about 3.2% of projects and project funds.

While we recognize that some projects had overlapping targets, e.g. Aboriginal Seniors, the main target is reflected in the figures below.

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[69] The information on targeting is included in this working document in order to present as complete a picture as possible, and was added to the Document Review after the completion of the original report. Where reference is made elsewhere in this document to work that would be done to review the issue of targeting funds, it should be assumed that such work has been carried out to the extent that the information was available.

TABLE 3: TARGET GROUP PROJECT FUNDING

	Youth	Women	Seniors	Abor.	DWI	Unknown	TOTAL
Actual (92-96) & Current budget (96-97)							
Health Serv. & Promotion	5.9	2.2	2.5	2.9	0.4	45.3	59.2
Health Protection						2.74	2.74
Medical Services				12.5			12.5
Secretariat						2.7	2.7
TOTAL	5.9	2.2	2.5	15.4	0.4	50.74	77.14
Expressed as percent	7.6%	2.9%	3.2%	20.0 %	0.5%	65.8%	

✓ **How were resources actually used, i.e. were they used for CDS purposes or other purposes?**

HPPB

Resources appear to have been used for CDS purposes.

Preliminary data on operational expenditures and project funding has been obtained from the Office of Alcohol, Drugs and Dependency Issues. The data covers an undetermined portion of the projects conducted by the Health Promotion Directorate, as well as the projects funded under the regional component of the Community Support Program.

MSB

Resources appear to have been used for CDS purposes, although the specific nature of activities funded through the regional level on reserve are not known at this time.

According to MSB personnel, MSB was allocated 2.5M per year under CDS, all Grants and Contributions funding. The allocation has not changed, i.e. there have been no cuts. Each year, 1.5M has been allocated to the on-reserve component, and 1M to the off-reserve component. Within the on-reserve component, 1.1M was "decentralized" to the regional offices. The remaining .4M remained at national headquarters and was allocated to two national level projects. For the off-reserve component, depending on the FY, between $500,000 and $750,000 was allocated to community based solvent abuse prevention projects.[70] The remaining dollars (out of the 1M total for off-reserve) were allocated to a nationally coordinated project, Youth Peer Counselling in Friendship Centres, in conjunction with OADDI.

Data on projects funds funded under the off-reserve component of CDS has been obtained, as has information on the two national level on-reserve projects.

HPB

Resources appear to have been allocated to CDS activities.

Preliminary Analysis and Possible Evaluation Issues

A preliminary review of project lists and other information suggests that the vast majority of CDS projects/activities appear to be in line with the activities mandated by the TB Submission. There are some areas that may need clarification, e.g. the extent to which DWI was addressed, the degree of targeting of general population/community, the difficulty of tracking the final targeting of MSB regional projects, etc.

Further Action for Evaluation

Financial information will be requested from the Bureau of Drug Research.

Project funding data for the on-reserve component administered by the regional offices may be solicited from the regions, if available, in order to analyze the expenditures by area of activity and target group.

✓ **If monies were reallocated, on what basis was this done?**

No evidence of reallocation at this time. Financial data not yet complete.

✓ **What would be the impact, should the CDS resources not be renewed?**

According to Departmental personnel, all activities that require HC funding would no longer continue (including research, program development, Grants and Contributions funding blocks, and national workshops), while policy development and coordination of activities would continue. It is unclear whether or not the CCSA will be able to achieve self-sustaining status to continue its work.

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[70] Three information packages that were sent out to request project proposals (in November 1993, December 1994 and January 1996). The cover letters indicated the amount set aside for funding projects was $750,000 in FY 1994/95, $750,000 in FY 1995/96, and $500,000 in FY 1996/97

DOCUMENT REVIEW REPORT - APPENDICES

A. INTENDED ACTIVITY AREAS - PHASE II
B. HEALTH CANADA CDS COORDINATION MECHANISMS
C. CDSS COORDINATION PROJECTS
D. CURRENT LOCATION OF HEALTH CANADA CDS COMPONENTS
E. CONTACTS FOR DOCUMENT REVIEW, RESOURCES REVIEW AND DATABASE REVIEW
F. CANADA'S DRUG STRATEGY - DATABASE REVIEW: HEALTH CANADA COMPONENT
G. DOCUMENT REVIEW GUIDE

APPENDIX A - INTENDED ACTIVITY AREAS - PHASE II

The MC and the TB Submission name some areas of responsibility specifically. The NHW Evaluation Framework 1992 is more detailed in this regard. Responsibility centres specifically mentioned in these planning documents are noted in the table below. (Please note: the current counterparts to these responsibility centres may now have different names/locations, see Appendix D for a list of current component locations.)

HEALTH CANADA CDS ACTIVITY AREAS				
MC	TB Submission	NHW Evaluation Framework 1992	**Responsibility Centres *** * Only those that were mentioned in the MC, TB Sub or Eval. Frmwk by name are listed here.	Activity Areas Undertaken
Education and Prevention •Awareness and Information • Training and Education • Community Support (Prevention and Treatment) •NNADAP Initiatives • Off-Reserve Native Programming • Drug Abuse Amongst Health Professionals	Education and Prevention • Community, family, school-based education and training programs re: alcohol, drugs, DWI • Develop/exchange information and materials • Provide Gs & Cs for prevention and treatment programs for children, youth at risk, first and subsequent DWI drivers, women, families (esp. effects of fetal alcohol syndrome and violence) • health care professionals substance abuse - rehab., re-integration, early det. & intervention • financial assistance to on and off-reserve aboriginal youth	Prevention • Public Awareness & Information • Education and Training • Community Support • Consultation & Coordination • Research & Monitoring	**Health Promotion Directorate (HPD), Health Programs and Services Branch (HPSB)** (NHW Eval. Frmwk, 1992) **National Health Research and Development Program (NHRDP), Health Services and Promotion Branch (HPSB)** (NHW Eval. Frmwk, 1992) **National Native Alcohol and Drug Abuse Program (NNADAP), Medical Services Branch (MSB)** (NHW Eval. Frmwk, 1992) **Bureau of Dangerous Drugs (BDD), Health Protection Branch (HPB)** (NHW Eval. Frmwk, 1992)	**HPD (HPPB)**[71] • Policy Development • Program Development • Consultations & Networking • Knowledge Dissemination and Skill Development • Community Support Program • Coordination/ Operational Planning **NHRDP** See below . **MSB**[72] • On-reserve Gs & Cs (primarily regionally administered, with two national level projects - National Addictions Awareness Week and National Native Role Model Program) • Off-reserve Gs & Cs (nationally coordinated program) **HPB**[73] •Drug Abuse among Health Professionals

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[71] Health Canada. Health Promotion Directorate. Workplans, 1993-94, 1994-95, 1995-96, 1996-97.

[72] Health Canada. Medical Services Branch. Advice to the Minister (briefing note dated March 18, 1996).

[73] Health Canada. Canada's Drug Strategy Secretariat. The Blue Book, 1994-95.

HEALTH CANADA CDS ACTIVITY AREAS

MC	TB Submission	NHW Evaluation Framework 1992	Responsibility Centres * * Only those that were mentioned in the MC, TB Sub or Eval. Frmwk by name are listed here.	Activity Areas Undertaken
Enforcement and Control • Drug Identification & Analysis • Drug Diversion Program •Implement New Legislation • Control of Precursors and Anabolic Steroids •Integrated Anti-Drug Profiteering Units	Enforcement and Control •Strengthen and coordinate policy underlying supply reduction activities (reflect Canada's international efforts) •Drug Identification and Analysis • New legislation • Control of Precursors and Anabolic Steroids • Integrated Anti-drug Profiteering Units	Enforcement and Control • Legislative and Policy Framework • Information • Drug Identification and Analysis • Methods of Analysis • Drug Diversion Prevention •Drug Abuse Prevention/ Control	**Drugs Directorate (DD), Health Protection Branch(HPB)** **Field Operations Directorate (FOD), Health Protection Branch (HPB)**	**HPB**[74] •Drug Diversion Prevention (monitoring of prescriptions, cases of multiple doctoring) • Drug Identification and Analysis • New Legislation (Controlled Drugs and Substances Act - Bill C-7) •Control of Precursors and Anabolic Steroids

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[74] Health Canada. Canada's Drug Strategy Secretariat. The Blue Book, 1994-95.

HEALTH CANADA CDS ACTIVITY AREAS

MC	TB Submission	NHW Evaluation Framework 1992	Responsibility Centres * * Only those that were mentioned in the MC, TB Sub or Eval. Frmwk by name are listed here.	Activity Areas Undertaken
Information and Research • NHRDP Initiatives • Targeted Research • Methods of Analysis	Information and Research • Targeted research on trends in alcohol/drug use with special attention to high-risk groups. New research will focus on youth (including street kids and drop outs), women, Native people. • Better prepared research teams to identify, synthesize and analyze new designer drugs • NHRDP to support research on target pops, and which reflects info needs of department.		NHRDP (MC, TB Sub)	**HPD** • Information & Infrastructure Support activities **NHRDP** • National consultation on research funding priorities for at-risk groups •Program of targeted research (Request for Proposals revised to reflect target groups; 9 projects approved for funding). • Programs of applied research on medication use in the seniors population (collaboration with Seniors Independence Research Program (SIRP)) • Community Researcher Awards Competition **CCSA** **MSB** • The Truth Healths (a report on consultations on solvent abuse and Aboriginal people). **HPB**[75] BDD automation system.

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[75] Health Canada. Canada's Drug Strategy Secretariat. The Blue Book, 1994-95.

HEALTH CANADA CDS ACTIVITY AREAS

MC	TB Submission	NHW Evaluation Framework 1992	Responsibility Centres * * Only those that were mentioned in the MC, TB Sub or Eval. Frmwk by name are listed here.	Activity Areas Undertaken
National Focus • CCSA (enhanced resources) • CDS Secretariat	National Focus • CCSA to provide leadership •CDS Secretariat to provide communications, coordination and evaluation within and across departments		CCSA (MC, TB Sub.) CDS Secretariat (MC, TB Sub.)	**CCSA** •Communications (Publications, Media Relations, Action News, Marketing) •Clearinghouse (Databases, Information networks, computer services, FAS Information service • Policy, Research & Information (Policy analysis, research coordination, data development) •Other (Liaison, Training, National conferences, Drugs in the workplace, Youth Network **CDS Secretariat**[78] •Coordination •Management •Policy Development •Evaluation •Communication and Visibility

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[78] Health Canada. Canada's Drug Strategy Secretariat. Workplans 1994-95

APPENDIX B - HEALTH CANADA CDS COORDINATION MECHANISMS

National:

Note: All mechanisms include HC and external partners (which may include provinces, territories, NGOs and members of the target groups):

Health and Enforcement in Partnership Steering Committee	
Minister's Business Advisory Council on CDS	CCSA (Phase I & II, disbanded)
National Steering Committee on Out-of-the-Mainstream Youth (OOMY)	(Phase II, no longer exists, project completed)
CCSA FAS Advisory Committee	CCSA (Phase I & II, ongoing)
CCSA Policy Group	CCSA (Phase I & II, ongoing)
Media and Substance Abuse Working Group	c/o CCSA (Phase I & II?)
CRTC Advisory Committee on Broadcast and Advertising of Alcoholic Beverages	(existed prior to CDS, ongoing)
Networking Group on Women and Substance Abuse Prevention	(Phase II, ongoing)
Street Lifestyle Working Group	(Phase II, existed to 1995)

F/P/T

F/P/T Working Group on Seniors and Medication	(Phase II)
F/P/T Working Group on DWI	Justice Canada has lead (new mandate, leadership under Phase II)
F/P/T Group on Alcohol and Other Drugs Issues	(ongoing)
F/P/T Research Committee on CADS	(Phase II, no longer exists as of April 1996, CADS released)

Interdepartmental

ADM's Steering Committee on CDS	(Phase I & Phase II, ongoing)
CDS Interdepartmental Working Group	(Phase II, on-going)
CDS Communications Working Committee	(Phase II, no longer exists as of April 1996)
Interdepartmental Committee on International Drug Issues*	FAIT (Phase I & II, on-going)
Interdepartmental Committee on DWI*	Justice (new mandate and leadership under CDS Phase II)
Interdepartmental Committee on Bill C-8	(Phase II, no longer exists, Bill passed)
Interdepartmental Committee on Transnational Organized Crime*	Not HC led.

* These committees have a mandate which extends beyond CDS.

Departmental

FAS Coordinating Committee	(Phase II, on-going)
Alcohol Policy Issues Group	(Phase II,on-going)
Seniors and Medication Working Group	(Phase II, on-going)
Controlled Drugs and Substances Act (Bill C-8)	(Phase II)

Branch (HPSB, later HPPB)

Note: These mechanisms owe their existence to CDS, but are not strictly CDS in terms of participation - all relevant players are included.

CDS Resource Group	(Phase II, no longer exists)
Street Lifestyles Working Group	(Phase II, no longer active)

APPENDIX C - CDSS COORDINATION PROJECTS[77]

Projects listed under Goal #1:

- Develop and disseminate Blue Book to CDS partners.

  Objectives: To develop an accurate, user friendly compilation of CDS program description; to ensure initiatives are consistent with the intent of the Strategy and MC; to provide updates to all Blue Book holders to keep them current on CDS program changes; to use Blue Book data to feed into Treasury Board report and requests for CDS data.

- To participate in Federal/Provincial/Territorial Consultation

  Objectives: To provide CDS partners with update on Phase II of CDS; to glean concerns and successes of partners; to maintain existing network and increase same; to reaffirm CDSS on [as?] the single entry point for coordinated information on CDS.

- To promote linkages between CDS and other Secretariats

  Objective: To promote a coordination of substance abuse activities as a horizontal issue.

- Program support and advice to the Minister of Health, lead Minister responsible for Canada's Drug Strategy.

  Objective: To provide sound and timely advice to the Minister on current and emerging issues surrounding CDS.

- To develop and deliver a regional enforcement workshop.

  Objectives: To provide participants with up-to-date information and tools related to their mandate; to enable participants to network and form new partnership; to identify through the workshop additional support CDS can provide.

- Maximize CDSS effectiveness through support and assistance. **(Marked "Deleted")**

  Objective: Provide input, advice and expertise to CDSS staff; represent on an ad hoc basis CDSS staff at meetings, conferences and like gatherings.

- Develop, expand and maintain a national enforcement consultations network.

  Objectives: To establish CDS enforcement Interdepartmental Committee; to expand scope of present partners to encompass municipal/provincial police; to join CACP and explore opportunities for collaboration; to facilitate joint undertakings between enforcement and health groups.

- Raise public awareness of DAW/NAAW at federal government level with special focus on Health Canada.

  Objective: To plan, develop and implement a corporate approach to DAW/NAAW.

- Establish Communications Working Committee on Canada's Drug Strategy.

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[77] This list is based on the documents reviewed. Departmental personnel have reviewed this list and their suggestions for changes have been incorporated.

Objective: To develop corporate approach to communications activities surrounding CDS.

- North American Conference on DWI.

  Objectives: To represent CDS on the issue; to obtain information on the latest program response to the offender population; to expand network.

- FAS Symposium in Saskatchewan

  Objectives: To represent CDS at Symposium; to provide visibility of role of CDS in topic; to provide substance abuse materials via display; to chair 2 sessions and discuss federal role in area.

- Federal/Provincial/Territorial Consultations on Phase II CDS

  Objectives: To provide jurisdictional partners with update on Phase I vs. Phase II; to obtain a sensitivity towards issues and needs of community partners; to establish new contacts for networking; to reaffirm CDSS as the single entry point for coordinated information on CDS.

- ARF International Symposium on Moderate Drinking

  Objectives: To learn about arguments and positions taken by scientists on the health benefits of moderate drinking; to participate in the debate of the pros and cons of moderate drinking from a health perspective; to act as a reviewer of a position paper on behalf of CDS (Policy Development); to expand network in the research field of substance abuse.

- CCMTA Safety Advisory Council Meeting

  Objectives: To provide advice and networking to CCMTA on road safety issues including DWI; to provide information to CCMTA and TAC members on the DWI aspects of CDS; to network with those involved with traffic safety and motor vehicle licensing; to provide input to upcoming International Conference on DWI.

- Out-of-the-Mainstream Youth Workshops

  Objectives: To provide research and program information to those in the regions responsible for working with target population; to expand and improve networking; to coordinate theoretical and practical bases for CDS prevention work with target groups.

- Local Grass Roots Coordination

  Objectives: To support activities that develop or expand community coordination; to expand current level of knowledge of community coordination.

- Respond to Information and Participation Requests **(marked: "Delete")**

  Objectives: To provide accurate and timely information to requests from within and outside the federal government; to participate in meetings as requested whenever feasible.

Projects listed under Goal #2:

- CICAD Evaluation Working Group (Objective: To participate as a member of the Mexico/Canada working group established to undertake an evaluation of CICAD).
- CICAD Meeting (Objective: To serve as a member of the Canadian delegation to the fourteenth and fifteenth regular sessions of CICAD)

- Meeting of the Commission on Narcotic Drugs (Objective: To coordinate preparation for the meeting of the Commission on Narcotic Drugs and serve as alternate head of the Canadian delegation to this meeting.)
- Definition of International Responsibilities of CDSS (Objective: To review and more clearly define the role of CDSS in representing Canada in the international area.)

APPENDIX D - CURRENT LOCATION OF HC CDS COMPONENTS

Original Component	Current Counterpart
Health Programs and Services Branch (HPSB)	Health Promotion and Programs Branch (HPPB)
Health Promotion Directorate (HPD)	Population Health Directorate (PHD)
Alcohol and Other Drugs Unit,HPD	Office of Alcohol, Drugs and Dependency Issues, Substance Abuse and Coordination Division, PHD
Education and Training Unit, HPD	Work and Education Health Promotion Unit, Systems for Health Directorate
Studies Unit, HPD	(drug component integrated into OADDI, May 1995)
Program Promotion Division, HPD	Marketing and Partnerships Division, Research and Program Policy Directorate
Community Support Program, HPD	OADDI (May 1995)
Canada's Drug Strategy Secretariat	Defunct
NHRDP, Extramural Research Division	NHRDP, Extramural Research Division, Research and Program Policy Directorate.
Medical Services Branch	Same
Addictions and Community Funded Programs, MSB	Health Programs Support Division, MSB
Health Protection Branch	Same
Drugs Directorate	Drugs Program
Bureau of Dangerous Drugs, Drugs Directorate	Bureau of Drug Surveillance Drugs Program
Bureau of Drug Research, Drugs Directorate	Bureau of Drug Research, Drugs Program
Field Operations Directorate (HQ)	Compliance and Regional Liaison Division, Bureau of Drug Surveillance, Drugs Program
Field Operations Directorate (regional offices)	Regional offices, Drugs Program

APPENDIX E - CONTACTS FOR THE DOCUMENT REVIEW, RESOURCES REVIEW AND DATABASE REVIEW

Diane Jacovella, OADDI

Francine Bélanger, OADDI

Bruce Rowsell, HPB

Odette Johnston, MSB

Margo Hawley, CCSA

Hervé Leblanc, HPSB

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APPENDIX F - DATABASE REVIEW

Introduction

One of the main purposes of Canada's Drug Strategy (CDS) is to improve the information base on alcohol and other drug related issues. Under CDS Phase II, Health Canada's role has been to upgrade information technologies and enhance database development. Improvements to the information base are intended to enhance the effectiveness of existing CDS programs and to improve cost efficiency.

Health Canada's information base is one of four mechanisms (i.e., information base, targeting, coordination, resources) that are being evaluated. These mechanisms do not operate in isolation from one another. For example, changes were made to program targets during CDS Phase II, were accompanied by altered methods for developing and enhancing data collection and analysis to achieve better information on high risk populations.

History of CDS Database Development

Health Canada has utilized and expanded on a wide range of data sources over the course of CDS. The database sources include: survey databases (e.g., national, provincial, territorial), electronic library databases (e.g., CCSA's Clearinghouse), internal databases (e.g., NHRDP's financial database), and various information reports on alcohol and other drug use (e.g., directories, inventories, profiles).

During CDS Phase I (1987/92), Health Canada created an information base on alcohol and drug-related issues based on general Canadian population data. For example, in 1989, Health Canada was responsible for conducting the first Canadian survey with a central focus on alcohol and other drug issues, the National Alcohol and Other Drugs Survey (NADS). The NADS resulted in the production of several reports that provided in-depth explorations of alcohol and drug topics among the Canadian population (e.g., Alcohol in Canada, 1989; Alcohol and Drug Use by Canadian Youth, 1989; Smoking Behaviours in Canada, 1989; Alcohol and Other Drug Use by Canadians, 1992). The Drinking and Driving Survey (1988) and the Health Promotion Survey (1990) both contained specific questions on alcohol and other drugs.

During CDS Phase II, the shift towards high risk population programming (e.g., youth, seniors, women, off-reserve aboriginal people, and impaired drivers) had a major impact on the manner in which data was collected and analyzed at Health Canada. Most notably, a Canada's Alcohol and Other Drugs Survey (CADS) was introduced in 1994.[78] A modified CADS (1995) was implemented in the Northwest Territories and the Yukon in order to properly represent the northern populations of Canada. This second survey demanded a methodology that was sensitive to the cultural and geographic realities of the north. As such, both quantitative and qualitative techniques were employed to conduct the second version of the CADS.

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[78] According to Departmental personnel, CADS, like NADS, was a general population not a high risk population survey, but, to a limited extent, it did try to identify high risk behaviours. It did not, however, reach many in the abusing sub-populations.

During CDS Phase II, increased attention was also directed towards applied research. For example, the CADS was more directed at applied research than the NADS, reflecting a higher level of consultation with CDS partners working in the areas of policy, program, and research. The dissemination strategy connected with the CADS extended beyond the traditional academic community to reach out to decision-makers and addiction health practitioners.[79]

Health Canada also produced a wide range of reports that accessed survey data collected by external partners.

Health Canada also used CDS funding to purchase "buy in" questions for Statistics Canada's General Social Survey (1993). Health Canada and the Canadian Centre for Substance Abuse (CCSA) were able to access the alcohol and drug questions from the GSS database in order to produce a series of reports. A series of FAS questions were also included in the National Population Health Survey (1994). Finally, the Yukon Alcohol and Drug Survey (1990) and Yukon Health Promotional Survey (1993) have generated important sources of information. These surveys enhanced the development and implementation of the second version of the CADS in the Northwest Territories and the Yukon.

Health Canada's internal database activities include work performed at the Health Promotion and Programs Branch, the Health Protection Branch, and through the National Health and Research Development Program. The Canadian Centre for Substance Abuse (CCSA) has had significant involvement in development database collection under CDS. The database activities of the CCSA and specific Health Canada branches is detailed below.

Canadian Centre on Substance Abuse (CCSA)

The CCSA plays an active role in improving the information base for CDS through their involvement in several substance abuse related projects. The CCSA's mission statement includes the objective to develop and apply knowledge and expertise in the areas relevant to Canada's drug problem.

The CCSA's National Clearinghouse on Substance Abuse (NCSA) was established in 1990. The Clearinghouse has the broad mandate to improve alcohol and other drug information in Canada. The Clearinghouse on Substance Abuse links all major sources of information on alcohol and other drugs into a single computer network. The Clearinghouse has developed several databases in collaboration with members of the Canadian Substance Abuse Information Network (CSAIN).

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[79] Departmental personnel note that NADS was also widely distributed outside the traditional academic community.

CCSA's promotional literature lists the following databases as currently available at the Clearinghouse. All of these databases have been fully active during CDS Phase II:

CANBASE: contains bibliographic information housed at CSAIN libraries and resource centres across Canada.

CANJNLS: contains a listing of serials held by CSAN libraries and resource centres across Canada.

DIRECTORY: contains a listing of Canadian organizations active in the substance abuse sector.

TREATMENT: an inventory of treatment services available across Canada.

CCSADOCS: contains bibliographic description for all documents and other media housed at the Clearinghouse.

Several of CCSA's automated databases are contained in report formats or on the internet. The CCSA has produced written reports on their **Directory of Substance Abuse Organizations in Canada** and the **Canadian Directory of Substance Abuse Services**. The CCSA's automated database collections can also be accessed by internet users through the World Wide Web.

Senior researchers working at CCSA have collaborated with Health Canada to produce several reports that are based on survey data (e.g., General Social Survey, 1993). In 1994, CCSA collaborated with the Health Promotion and Programs Branch in producing the **Horizons** series on Alcohol and Other Drug Use in Canada. **Horizons 1994** was the first research-based publication to emerge from CDS Phase II. This report draws on national and provincial data sources to produce a comprehensive overview of emerging developments in all the provinces and territories in terms of alcohol and other drug use.

Horizons 1994 and the following series of **Horizons** (One - "Older Canadians", Two - "Women", and Three - "Young Canadians") extensively report on the substance abuse patterns of selected high risk populations. **Horizons 1994** includes detailed information on the patterns of alcohol and other drug use among aboriginal people and impaired drivers across Canada. The information reported in the **Horizons** series examines survey data on youth, seniors, and women. The **Horizons** series is targeted at a wider audience than previous reports in the field, including researchers, decision-makers, and practitioners.

CCSA collaborated with the Addiction Research Foundation (ARF) in producing the written report, **Canadian Profile** (1993 and 1995). This national report on the nature and extent of alcohol and other drug abuse includes statistics on crime, deaths, public attitudes, and hospital separations. Canada's Drug Strategy was the major funding agent for this publication.

The CCSA's recent report **The Costs of Substance Abuse in Canada** (1996) is based on extensive consultation at the national and international level. International guidelines on the methodology for such studies were the focus of two international symposia and these guidelines were developed by a small international working group of symposia participants. This methodology was applied in **The Costs of Substance Abuse in Canada** (1996) study. The study was conducted by CCSA and ARF in collaboration with persons from Health Canada, University of Toronto and the Université de Montréal.

Health Promotion and Program Branch (HPPB)

A significant component of all CDS sponsored database development derives from the activities of the Health Promotion and Programs Branch (HPPB). The HPPB's Office of Alcohol, Drugs and Dependency Issues is involved with the majority of the database collections. The development and analysis of these data sets is often performed in collaboration with other CDS partners. For example, CCSA and HPPB worked together to produce the **Horizons** series of reports.

In 1994, HPPB conducted the CADS to update and expand on data collected in the first National Alcohol and Other Drugs Survey (NADS). Although the NADS forms the base, the CADS attempts to fill gaps identified in the earlier 1989 instrument in several areas. The CADS also provides a more comprehensive examination of the patterns of illicit drug use in Canada. Finally, the CADS taps into behavioral indicators linked to substance use (e.g., situations of use, triggers leading to use, problems associated with use). A more in-depth overview of these shifts in data collection are found in the Health Canada's report, **Canada's Alcohol and Other Drugs Survey 1994: A Discussion of The Findings (1996)** and Statistic Canada's, **Microdata User's Guide: Canada's Alcohol and Other Drug Survey (1994)**.

The CADS directly addressed the need to develop a knowledge base on three of the main five high risk populations identified in CDS Phase II, namely women, seniors, and impaired drivers.[80] The second version of the CADS (Northwest Territories and the Yukon) is designed to capture information on aboriginal people, women, and young people. There was no intention of providing coverage to "out-of-the-mainstream" youth in the CADS because this population requires more expensive use of alternative methods of data collection (eg. qualitative and quantitative research techniques). In other words, surveys are weak in capturing information on transient populations (e.g., contacting drop outs by phone surveys is problematic).

Other research studies focused on out-of-the-mainstream youth, including **A Study of Out-of-the-Mainstream Youth in Halifax, Nova Scotia** and the **Street Lifestyle Study**.

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[80] Departmental personnel note that CADS was subject to the limitations of a random digit dialling telephone survey which, for obvious reasons, misses much of the high risk/abusing population per se.

In addition to the NADS and CADS, HPPB had collaborated with several CDS partners to improve the information base. HPPB worked closely with CCSA, NHRDP, and several provincial governments and agencies in order to improve the information base for the CDS.

National Health Research and Development Program (NHRDP)

The National Health Research and Development Program (NHRDP) supports the development of an internal database through their extramural research on health issues. During CDS Phase II, NHRDP's research projects have focused on high risk populations (seniors, women, off-reserve aboriginal, and out of the mainstream youth). In 1993, NHRDP sponsored a workshop to establish priorities for funding research on high risk populations.

NHRDP collaborated with departmental staff at the Office of Alcohol and Other Drugs Unit to develop Requests for Research Proposals for high risk groups. The Seniors Independence Research Program (SIRP) works in the area of medication use among senior populations. NHRDP also sponsors applied research through their Community Researchers Awards.

NHRDP's financial data is coded into its own database entitled "NHRDP database". The software program for the database generates reports on budgeted funds, actual expenditures by activity area, and by target group. The NHRDP database also uses a classification system to manage information on CDS sponsored projects.

Health Protection Branch (HPB)

The Bureau of Drug Surveillance (BDS) administers the *Narcotic Control Act* and Part III and IV of the *Food and Drugs Act*, as well as regulations under both acts. BDS coordinates its activities with provincial licensing authorities of health disciplines and with law enforcement agencies at the national, provincial, and municipal levels.

The NARCON is the mainframe computerized system that became operational at the BDS in 1990. The NARCON was developed to monitor the movement of licit drugs in Canada and to monitor the consumption of drugs by individuals. BDS relies on the NARCON to generate a relational database that is composed of 286 tables and 179 forms. The NARCON tables contain information on BDS clients such as individuals (e.g., pharmacists, physicians, drug offenders) and institutions (e.g., pharmacies, hospitals, licensed dealers). The current party table contains 192,426 records.

NARCON contains additional modules that have been developed and enhanced since CDS Phase II. For example, the system is now capable of monitoring methadone consumption as well as producing dealer licences and import and export permits. The NARCON is also capable of producing reports for the International Narcotics Control Board and the United Nations on the quantity of drugs imported to and exported from Canada.

APPENDIX G - DOCUMENT REVIEW GUIDE

Document Review Guide

June 11, 1996

HEALTH CANADA'S CONTRIBUTION TO CANADA'S DRUG STRATEGY

The first step in the final evaluation of Health Canada's contribution to Canada's Drug Strategy is a review of relevant documents.

With your assistance, we will review those documents that help answer questions in the following areas:

1) Enhanced Programming

The overall objective of the CDS is to reduce harm to individuals, families and communities caused by problem alcohol and other drug use. (Evaluating this objective will be dealt with by the interdepartmental final evaluation.) Secondly, the CDS was intended to make its harm reduction activities more effective by ***enhancing existing programming.*** *Therefore, we will be trying to answer the following questions:*

i. How was Canada's Drug Strategy intended to strengthen Health Canada's prevention, enforcement and control programs?

ii. What changes have their been, if any, to prevention, enforcement and control programs under the CDS?

iii. Have Health Canada's prevention, enforcement and control programs become more cost-effective?

iv. Are there clear lines of accountability within the Department for CDS initiatives and the CDS strategy as a whole?

2) Strategies to Enhance Programming

Strategies to enhance Health Canada's existing programming were to include improved targeting, coordination, information collection and resource utilization. Consequently, we will try to answer questions related to the following areas:

a) Improved Program Targeting

Under CDS, Health Canada intended to work "smarter" by targeting programs to specific sub-populations (i.e. to reap greatest benefit for the money invested and to improve on the information base for policy and programming decisions). Phase II of the CDS has seen a number of changes in target populations, as the emphasis has moved to prevention for high-risk groups, including street kids, drop-outs, off-reserve aboriginals, unemployed, seniors, women, dysfunctional families.

i. Have programming targets changed under the CDS?

ii. How have programming targets changed?

iii. What was the basis for these changes?

iv. How have changes to programming targets impacted on how well programs have met their objectives?

b) Improved Coordination and Co-operation

Under CDS, Health Canada intended to improve effectiveness of existing programming by introducing a strong measure of coordination.

i. How did the CDS improve coordination and co-operation within Health Canada, and between Health Canada and other departments?

ii. What action was taken to improve coordination and co-operation.?

iii. How have actions to improve coordination and co-operation impacted on how well programs have met their objectives?

c) Improved Information Base

Health Canada was supposed to develop better information and improve the use of that information in program and policy development decisions.

i. How did Health Canada intend to improve its information base?

ii. What improvements been made to Health Canada's information base?

iii. How has Health Canada used the information that benefited from the CDS?

iv. What effect of this information had on programming?

d) Utilization of Resources

We will be examining how closely the reality of resource allocations and expenditures over the life of the Initiative resembled the original allocations for the CDS.

i. What increase in resources was Health Canada to receive from CDS?

ii. What resources did Health Canada actually receive from CDS?

iii. How were resources were actually used, i.e. were they used for CDS purposes or other purposes?

iv. If monies were reallocated, on what basis was this done?

v. What impact did these resources have on programming?

vi. What would be the impact, should the CDS resources not be renewed?

We expect this information will be contained in a variety of documents, including the following types of documents:

- Minutes from interdepartmental meetings
- Documentation of interdepartmental procedures

- Organizational charts

- Briefing notes
- Relevant correspondence at the senior management level

- Planning reports
- Work plans
- Project reports/evaluation reports (Note: we will not review all project files, but will select projects for review at random. Please provide access to all project files.)

- Data base specifications and descriptions
- Reports on the development/implementation of data bases
- Reports commenting on the results of newly developed data bases
- Documents that indicate the links between Phase I and II of CDS in terms of data base development

- Communications plans
- Correspondence with stakeholders and the general public
- Media clippings and reports

- Budgets, expenditures and financial records. (Note: we are interested in financial information at the Program, rather than the Project level.)

Thank you for your cooperation.

PART II: LITERATURE REVIEW

December 18, 1996

Jamieson, Beals, Lalonde and Associates, Inc.

I. INTRODUCTION

This review focuses on literature that has been produced on substance abuse prevention programming and high risk populations since the initiation of the Canada Drug Strategy (CDS) Phase II in 1992.

The main objectives of the review are to:

- highlight key developments in the area of high risk populations identified in the Canada Drug Strategy Phase II[81];
- examine current issues/trends in community-based substance abuse prevention programming; and,
- review the findings from outcome evaluations that measure program effectiveness of prevention programs for high risk populations.

II. METHODOLOGY

The literature review was based on a search strategy that focused primarily on North American literature appearing between 1992 and 1996 relevant to substance abuse prevention programs as applied to the five high risk populations identified in the CDS Phase II[82]. Three main sites were accessed to conduct the searches: 1) the Health Programs and Services Branch; 2) the Canadian Centre on Substance Abuse's Clearinghouse; and, 3) Health Canada's Departmental Library. Several computerized searches were conducted at the various sites. The key database searches included: CCSA's Clearinghouse (e.g., CCSADOCS and CANBASE) and the databases at Health Canada's Departmental Library (e.g., in-house library database, ERIC, Sociofile).

The above information sources were tapped to yield general information, program overviews, research reports, outcome studies, survey reports, prevention manuals, and conference proceedings that have been published on substance abuse prevention and high risk groups over the past five years[83].

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[81] This includes: out-of-the mainstream youth, women, seniors, Aboriginal peoples and impaired drivers.

[82] Due to resource and time constraints, the literature review was limited to the past five years; consequently, it is not an exhaustive review of published research on substance abuse prevention.

Given the time frame and resource constraints associated with this study, this is not an exhaustive review of the literature on substance abuse issues. We are confident, however, that the main trends and issues relevant to the CDS Phase II evaluation at this time have been identified.

III. FINDINGS

A. Current Trends in the Prevalence of Substance Abuse among the Canadian Population

The National Alcohol and Other Drug Survey (1989) and Canada's Alcohol and Other Drug Survey (1994), funded by the CDS, were the first surveys in Canada to exclusively focus on alcohol and other drug consumption issues. CDS funding was used to develop alcohol and other drug questions that were included in the 1993 General Social Survey. These databases have generated a wealth of information on general trends associated with the use of alcohol and other drugs among the Canadian population. Although the CADS (1994) was designed as a general population survey, it contains information on several high risk groups (e.g. women, seniors, impaired drivers).

The most recent and comprehensive overview on general alcohol and other drug use trends among the Canadian population is found in Health Canada's 1995 report, Canada's Alcohol and Other Drugs Survey 1994: A Discussion of the Findings. The key general population trends can be summarized in the following manner:

Alcohol Consumption: Over the past fifteen years, there has been an overall decline in the proportion of Canadians reporting alcohol consumption.[84] Despite the recent declines, drinking patterns in the population vary according to several socio-demographic patterns. For example, characteristics associated with heavy/infrequent drinkers are different from heavy/frequent drinkers.[85] Characteristics associated with the heavy infrequent pattern are: being male, being between ages 15-34 (and particularly 15 and 19), living in Atlantic Canada, and/or having not completed secondary school. Characteristics associated with heavy/frequent drinkers are: being between ages 18-44 (especially between 18-24), living in Atlantic Canada, being single or never married, having less than secondary school education, and/or lower income. Socio-demographic characteristic continue to vary as the amount and frequency of alcohol consumption declines.

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[83] We acknowledge that much of the research done in the past decade has contributed to the shape of the CDS, however it was not possible within the time frame to review more than a five year time frame.

[84] **These findings are exclusively based on national survey data.**

Overall, 72.3% of Canadians aged 15 years and older reported drinking in the past 12 months according to the CADS (1994).

Tobacco Consumption: Rates of smoking have declined substantially over the past thirty years (with some stability over the past five years). However, the CADS identifies young people (15-19 years old) as a group with an increased prevalence of smoking.

Overall, 27.0% of Canadians aged 15 and older reported smoking in the past twelve months according to the CADS (1994).

Licit Drug Use: There appears to be a slight downward trend in the use of licit drugs (i.e. prescription tranquillizer and sleeping pills) over the past decade. Several characteristics are associated with the use of prescription drugs, notably that: females are more likely to use prescription drugs than males, and older people and separated, divorced, or widowed people have a higher rate of prescription drug use.

Overall, 20.8% of Canadians aged 15 and older reported using medications in the past twelve months according to the CADS (1994).

Illicit Drug Use: The proportion of Canadians reporting the use of illicit drugs (e.g. marijuana, cocaine, crack, LSD, amphetamines, heroin) remained fairly stable between

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[85] Heave/infrequent drinkers use alcohol less than once a week, but have 5 or more drinks when they drink. Heavy/frequent drinkers have alcohol once a week or more and five or more days on days they drink. See Health Canada, Canada's Alcohol and Other Drugs Survey 1994: A Discussion of Findings.

1989 and 1994.[86] Illicit drug use is a trend found primarily among youth and twice as often among males.

Overall, 23.9 % of Canadians aged 15 and older reported using illegal drugs in the past twelve months according to the CADS (1994).

B. The Costs of Psychoactive Substance Use within the Canadian Population

The Canadian Centre on Substance Abuse (CCSA) recently published the first major study on the health, social and economic costs associated with the use of all psychoactive substances (alcohol, tobacco and illicit drugs) in Canada (Canadian Centre on Substance Abuse: 1996)[87]. The study estimated that substance abuse costs $18.45 billion in Canada in 1992, broken down according to the follow drug types:

Alcohol	Tobacco	Illicit Drugs
$7.5 Billion	$9.6 Billion	$1.3 Billion

The CCSA study further broke down the $18.45 billion in substance abuse costs (1992) into six specific areas of spending. Costs are broken down into the millions of dollars:

■ the workplace	$ 20.1
■ administrative costs for transfer payments	$ 53.8
■ prevention and research	$ 231.1
■ other direct costs	$ 545.8
■ law enforcement; and,	$ 1,759.4
■ direct health care costs.	$ 4,064.1
■ indirect costs - productivity losses	$ 11,778.4

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[86] Despite the reported stability in illicit drug use among the general population, regional data can be explored to highlight trends among the high risk groups. For example, the Addiction Research Foundation's Ontario Drug Use Survey (1995), revealed that there was a significant increase in nine illicit drug types (e.g., cannabis, cigarettes, glue, speed, cocaine) among 12 to 19 year olds attending provincial schools. Refer to Addiction Research Foundation, The 1995 Ontario Student Drug Use Survey (Draft) Toronto: ARF, 1995. For a more detailed examination of high risk populations on a regional basis, refer to Eric Single et al., Horizons: Alcohol and Other Drug Use in Canada Ottawa: Health Canada, 1994.

[87] This study received funding support from the CDS Phase II.

The CCSA's Costs of Substance Abuse Study also contains detailed figures on the relationship between substance-related mortality and morbidity as a proportion of all causes. The study estimated that there were 40,930 deaths attributable to substance abuse in Canada in 1992. Tobacco accounts for 33,930 deaths, alcohol 6,701 and illicit drugs 732. This represents 21% of total mortality for that year. The number of hospitalizations due to substance abuse constitutes 8% of total hospitalizations in Canada.

Overall, the CCSA study determined that 2.7 % of the Canada's Gross National Product is consumed by costs associated with alcohol, tobacco and illicit drugs in Canada. Providing the first reliable estimates on the costs associated with substance use in Canada, this study can be taken as a critical starting point to developing supply control/demand reduction strategies to prevent substance abuse.

C. Key Issues and Developments within High Risk Populations

Five high risk groups were identified as central target populations under the CDS Phase II: 1) Out-of-the-mainstream youth; 2) Women; 3) Seniors; 4) Aboriginal peoples; and, 5) Impaired Drivers.

1. Out-of-the-Mainstream Youth

Defining Out-of-the- Mainstream Youth

Out-of-the-mainstream youth are a transient, heterogenous sub-population that is difficult to clearly define (Brannigan and Caputo, 1993; Anderson, 1993; Smart et al., 1990; and, Finkelhor et al., 1990). It is important to make the necessary distinctions between the various types of out-of-the-mainstream youth. Recently, researchers have characterized out-of-the-mainstream youth according to several sub-groups (Caputo et al., 1996). Brannigan and Caputo (1993) identified several different terms that describe this elusive group, including: "runaways", "curbsiders", "throwaways", "societal rejects", "missing children", "homeless youth", "street youth" and "youth at risk".

In relation to runaways, a study by Anderson (1993) highlights the differences between "runners" who stay away from home for long periods (sometimes never returning), and "in and outers" whose absences are temporary and who may leave and return home on multiple occasions. Recent examinations of out-of-the-mainstream youth continue to explore key differences within this sub-population (Caputo et al., 1996). For example, distinctions have been made in relation to whether or not out-of-the-mainstream youth live at home, the amount of time they spend on the street and their involvement in risky or illegal behaviours (Caputo et al., 1996). More specifically, Anderson (1993) and Caputo et al., (1996) dealt with antecedents of adopting a street lifestyle, and the transition process in achieving social stability.

Size and Characteristics of the Out-of the- Mainstream Youth Population

The fluidity of this sub-population presents difficulties in terms of accurately estimating the number of out-of-the-mainstream youth in Canada.[88] Different social agencies offer fluctuating estimates of the number of street youths in Canada's urban centres (Brannigan and Caputo, 1993). Covenant House has estimated that there are 150,000 Canadian "runners" but these estimates vary widely (Radford, 1989).[89] In the United States, estimates of this high risk population range from the hundreds of thousands to several million (Brannigan and Caputo, 1993; Goplerud, 1992).

There is general agreement in the literature that the age range for out-of-the-mainstream youth is from approximately 12 to 24 years (Brannigan and Caputo, 1993). There are no systematic estimates on the proportion of male versus female out-of-the-mainstream youth population across Canada although it appears that the proportion of females may be increasing (Anderson, 1993).

Trends and Patterns of Substance Abuse Among Out-of-the-Mainstream Youth

There is widespread agreement that out-of-the-mainstream youth experience multiple problem behaviours alongside alcohol and other drug problems. Family instability and youthful conflict with parents is closely (but not in every case) associated with running away from home (Price, 1989). A related dimension involves the physical, sexual, and emotional abuse of young people at home and the resulting impact on running behaviour and delinquent acts such as prostitution and drug dealing (Brannigan and Caputo, 1993; Whitbeck et al., 1990). The psychological distress associated with out-of-the-mainstream youth has led researchers to examine several characteristics, including intelligence levels, low self-sufficiency, hostility, isolation, and psychopathy (Brannigan and Caputo, 1993), as well as other dynamics (e.g. school system stresses leading to dropping-out) that may lead to the adoption of a street lifestyle (Caputo, 1996).

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[88] It may be useful to first examine the overall youth population in Canada before exploring out-of-the-mainstream youth. Statistics Canada reported that there were 5,708,525 young people (ages 10 to 24 years old) across Canada in 1991. It is worth noting that out-of-the-mainstream youth are classified according to a slightly different age breakdown (i.e., between the ages of 12 to 24 years old). Refer to, Statistics Canada, The Nation. Ottawa: Catalogue 93-310, 1993.

[89] The RCMP collects official estimates on the number of missing children in Canada. The total number of missing children reported to police across Canada was 55,759 in 1995. The overwhelming majority of the cases reported (93%) concern children between the ages of 12 and 17 years old. The majority of the missing children cases (78%) reported to police departments fall into the category of runaways (other categories include abductions, wandered off/lost, accidents, and unknown). Refer to, Royal Canadian Mounted Police, Canada's Missing Children: 1995 Annual Report: Missing Children Registry. Ottawa: RCMP, 1995.

In terms of firm empirical data, there are no exact figures on the scope of substance abuse problems among out-of-the-mainstream youth across Canada.[90] There is, however, strong anecdotal evidence from workers in the field that emphasizes that out-of-the-mainstream youth are at a higher risk for substance abuse dependence than mainstream youth (Caputo et al., 1996). In addition, regional surveys of homeless children and youth have produced evidence of substance abuse among this high risk population. For example, one study on runaway youth in Winnipeg revealed that a range of high risk behaviours (e.g. unprotected sexual activity, substance abuse, criminal behaviour) are closely associated with this target population (Social Planning Council of Winnipeg, 1990). Overall, out-of-the-mainstream youth are at risk for experiencing a range of social, psychological, and physical problems, including substance abuse (Caputo et al., 1996).

Services for Out-of the-Mainstream Youth

Providing substance abuse prevention and treatment services to out-of-the-mainstream youth has been found to be quite difficult because this group is usually distrustful towards conventional, institutional-based services. Therefore, practitioners and experts view specialized services as necessary to properly address the needs of out-of-the-mainstream youth. Social agency staff are the primary service providers to out-of-the-mainstream youth. The majority of service provision to the target group is provided through a basic maintenance category (e.g. food, clothing, shelter, medical) or through a transitional category (i.e. support in moving off the street) (Anderson, 1993).

"Peer helper" initiatives constitute a secondary source of service provision to out-of-the-mainstream youth with substance abuse problems. An extensive review of prevention services for young Canadians is located in the recent Health Canada document, Peer Helper Initiatives for Out-of-the-Mainstream Youth: A Report and Compendium (1996). In this report, "peer helpers" are defined in a broad sense to include a range of programs in which young people provide service to other young people.

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[90] Regional data clearly documents an increase in substance use among young Canadians (e.g., 12-19). For example, the ARF's Ontario Student Drug Use Survey (1995), revealed an increasing pattern of illicit drug use among young people in Ontario between 1993-95. It is worth noting that this survey targeted youth within the general population as opposed to a specific high risk group. Nevertheless, a general trend does exist in terms of increased usage of illicit substance among youth in Ontario.

"Peer helpers" typically work through agencies offering a range of substance abuse services (including education, prevention, and treatment) and other services (e.g. contact/support services, transition/reintegration services) (Caputo et al., 1996). The variation in the types of programs offered across Canada is directed at matching the diverse needs of out-of-the-mainstream youth to programs (e.g. substance abuse prevention programming, HIV/AIDS prevention, prostitution prevention, runaway prevention, school dropout prevention, suicide prevention, violence prevention, telephone services and peer support).

While there is now a substantial amount of information available on the range and types of peer helper initiatives that are offered across Canada (Caputo et al., 1996), there remains an absence of systematic and well controlled outcome research that measures the effectiveness of these types of interventions. One of the main conclusions of the Peer Helper Initiative report (1996) is that although the use of these interventions has often been proven to be effective (through anecdotal evidence and process evaluations), more investigation is required to properly establish and assess the validity of the outcome results.

2. Women

Trends and Characteristics of the Substance Use Patterns of Women

In recent years, a large body of survey data has accumulated on the specific patterns of alcohol and other drug use among women in Canada (e.g. NADS, 1989; CADS, 1994; and, the Health Promotion Survey - HPS, 1990). The CADS is particularly sensitive to gathering gender relevant information on women's alcohol and drug use. Trend data now reveals that women are catching up to men in their tobacco consumption. Moreover, the chances of women being harmed by tobacco may equal or exceed the likelihood of alcohol-related harm (Hewitt et al., 1995a). According to more recent data women now represent approximately one-third of those who die from tobacco-related causes. Regarding alcohol-related deaths, for women, the number of potential years of life lost due to alcohol-related accidental deaths and suicides equals 51,762, as compared to 134,495 potential life years lost for men (CCSA, 1996).

In recent years, significant attention has been directed to prevention programming to combat fetal alcohol syndrome and fetal alcohol effects (FAS/FAE). It is not surprising that attention has been directed at this problem given that alcohol is a major cause of birth defects and mental retardation in Canada and the United States (Single et al., 1994; Schorling et al., 1992). FAS/FAE is a particular concern for aboriginal peoples in Canada (Single et al., 1994). The general trends towards increased alcohol consumption among women and decreases in the age of first use are major factors that contribute to health and social problems (Hewitt et al., 1995a; Health Canada, 1992).

The substance abuse prevention literature for women contains a substantial number of references to the topic of FAS/FAE. Among the five high risk populations examined in this report, the topic of prevention programming and FAS is well documented in the evaluation literature.[91] These evaluations will be discussed in the later stages of this review.

Women and Prescription Drugs

Women's use of prescription drugs (e.g. prescribed pain pills, sleeping pills, tranquillizer, anti-depressant, diet pills) continues to be a major area of concern for this high risk group. The rate of women's prescription drug use (i.e. tranquillizer and sleeping pills) continued to decrease from 1985 to 1994. Nevertheless, a much larger proportion of women reported using prescription drugs in 1994 when compared to men (MacNeil and Webster, 1995). Overall, women's pattern of use and life circumstances differ from the male population and therefore require gender-specific solutions and programming.

Services for Women with Substance Abuse Problems

Survey research and clinical findings suggest that substance abuse prevention for women must address the specific needs of this high risk population (Lightfoot et al., 1994). Women with alcohol and other drug problems must address issues that are not dealt with in traditional male programs, including: physical and sexual abuse, physiology (e.g. body image and body size), fetal alcohol syndrome and effects (FAS/FAE), and gender-specific patterns of use (e.g. abuse of prescription drugs), and consider child care provisions and child welfare issues while the woman is participating in treatment. There is also the need to tailor programs to different groups of women, such as: aboriginal, multicultural, disabled, and young women (Health Canada, 1993). The number and scope of gender-based substance abuse programs and services in Canada is not known.

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[91] The five high risk population are: "out-of-the-mainstream youth"; women, seniors, off-reserve aboriginal peoples, and impaired drivers.

3. Seniors

Trends and Characteristics of Substance Use Patterns among Seniors

Older Canadians' alcohol and other drug use, particularly prescription drug use, is one of the key elements identified in CDS Phase II.[92] Since the senior population in Canada is expected to grow rapidly over the next twenty-five years, there is increased emphasis to develop strategies to help older Canadians with alcohol/drug problems (e.g. combining alcohol consumption and prescription drug use). There are several groups in society that have a direct role to play in dealing with older Canadians' use of alcohol and other drugs, including: seniors organizations; addictions organizations; community groups; aboriginal communities, professional organizations; pharmaceutical and alcohol industries; researchers; and other concerned groups.

In Canada, several reports carefully detail several distinct patterns of alcohol and other drug use among seniors (e.g. Hewitt et al., 1995b; Health Canada, 1995; Smart and Adlaf, 1988). Although there are fewer current drinkers among older Canadians when compared to younger Canadians, alcohol remains the most common drug used by older persons (over 60% are current drinkers) (Hewitt et al., 1995b). The CADS demonstrates that older Canadians report a much lower incidence of harm caused by their own alcohol use compared to younger Canadians (Health Canada, 1995a).[93]

Canadian survey data indicates that the use of prescription drugs increases with age (NADS, 1989; CADS, 1994; and the Health Promotion Survey, 1990). Moreover, there is evidence that older people tend to make more mistakes when taking medications such as taking additional quantities of drugs or not following directions properly (Hewitt et al., 1995b). The use of illicit drugs among older Canadians is rare. Overall, alcohol and medication use are potential high risk areas of behaviours for older Canadians.

Human physiology can produce negative effects on the alcohol and other drug use patterns among older Canadians. The medical evidence is clear that the body functions less effectively for older Canadians in several areas, including: the central nervous system functions (e.g. memory, hearing, vision), kidneys, and the liver. As a result, older Canadians are at greater risk for harmful consequences because of the physiological changes associated with aging (Health Canada, 1995b). The undesirable use of medications can occur when seniors ignore directions (or receive poor instructions from doctors), misuse prescription drugs (e.g. over-or-under use), and through the effects of multiple drug use (Health Canada, 1995b).

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[92] CDS defines older Canadians as adults that are aged 55 and over as opposed to the conventional definition of aged 65 and over.

[93] It should be noted that many seniors with serious conditions associated with alcohol abuse reside in hospitals and long term care facilities. This factor should be considered given that the CADS did not survey these types of facilities.

Services for Seniors with Substance Abuse Problems

Several governmental and non-governmental organizations are involved in the delivery of substance abuse prevention services for seniors with alcohol and other drug problems (e.g. Bergin and Baron, 1992; Addiction Research Foundation, 1993a; SADAC, 1990; Canadian Medical Association, 1993). For example, a recent national workshop dealing with "Seniors and Medication, Alcohol and Other Drugs", reported that the Health Canada Components of Canada's Drug Strategy were responsible for funding over thirty-five community projects for seniors with substance abuse problems (Health Canada, 1995b).

4. Métis, Inuit and Off-Reserve Aboriginal Peoples

Trends and Characteristics of the Substance Use Patterns among Aboriginal Peoples

Horizons 1994: Alcohol and Other Drug Use in Canada includes a regional profile of the substance abuse patterns among aboriginal peoples in Canada. The report documents examples where aboriginal communities have achieved success in reducing alcohol and other drug related harm (e.g. Yukon). Nevertheless, the overall trend points to a high incidence of substance abuse problems among aboriginal peoples. For example, alcohol and drug problems were identified as far greater than any other problems (e.g. unemployment, child abuse, housing, prejudice) among aboriginal peoples living off-reserve in Vancouver, British Columbia (Single, 1994). In Alberta, researchers point out that aboriginal peoples experience significantly more problems with alcohol than do non-aboriginals (Single, 1994). Horizons 1994 also highlighted the over-representation of aboriginals in drug treatment centres in provinces such as Saskatchewan and Manitoba.[94]

The designation of aboriginal peoples as a high risk group is directly linked to their unique pattern of alcohol and other drug use. For example, aboriginal young people have a greater lifetime prevalence and earlier age at substance use onset; most strikingly for smokeless tobacco and solvents (Nechi Institute, 1994). Issues such as suicide, sexual abuse, family violence, unemployment, and poverty are all closely linked to substance abuse problems among aboriginal peoples (Nechi Institute, 1994; Health Canada, 1994c; Health Canada, 1994d).

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[94] The release of Health Canada's upcoming 1996 report, Canada's Alcohol and Other Drug Survey 1994: Yukon and Northwest Territories, will contribute to the information base on the northern populations of Canada.

The Nechi Institute have pointed out that across age and sex groups, aboriginal populations in Canada are roughly three to four times more likely to die violently than their mainstream counterparts. For aboriginal adolescents, suicide rates are six times the national adolescent average and alcohol consumption is conservatively estimated to be twice that of the national adolescent population (Nechi Institute, 1994).

Services

Aboriginal community involvement in and control of substance abuse programming has been promoted on many fronts. It was recently reported that, "the 382 prevention programs, 50 treatment programs, inhalant abuse programs and the research initiatives funded by Health Canada are all staffed and governed by Aboriginal Boards of Directors/or Chief of Councils (Nechi Institute, 1994). Health Canada has also worked closely with national aboriginal organizations to develop and implement prevention services for off-reserve solvent-abusing youth (Health Canada, 1994a; Health Canada, 1994b).

The substance abuse literature on aboriginal peoples suggests that alcohol and other drug prevention services must address the multiple needs within these communities (e.g. sexual abuse, family violence, suicide, poverty). The majority of prevention services for aboriginal peoples are holistic in nature in order to address the broader social context of substance abuse problems among this high risk group (Health Canada, 1995c).

4. Driving While Impaired (DWI)

Trends Related to Driving While Impaired

Driving while impaired (DWI) is another priority for the CDS Phase II. Although DWI has declined in the past ten years, it remains a serious problem in Canada. For example, the results from the 1994 Canada's Alcohol and Other Drug Survey (CADS) indicates that approximately one in five current drinkers (20.3%) drove after consuming two or more drinks in the previous hour (compared to the NADS finding of 22.8% in 1989) (Health Canada, 1995d). Moreover, among those killed on Canadian roadways in 1992, 48% had been drinking and driving (Health Canada, 1994e).[95] The Costs of Substance Abuse study indicates that motor vehicle deaths comprise 22% of all alcohol-related deaths; young persons comprise many of these deaths (CCSA 1996).

Services to Address DWI Offenders

Health Canada was responsible for producing two major reports on DWI during CDS Phase II. Dealing with DWI Offenders in Canada: An Inventory of Procedures and Programs (1994), contains a detailed list of provincial procedures and comprehensive program lists for first and repeat offenders. Health Canada is also in the process of releasing a second report on DWI, Literature Review of the Characteristics of Driving While Impaired Repeat Offenders (1996).[96]

D. Main Trends in Community-Based Substance Abuse Prevention Programs

1. General and High Risk Populations

Reviews of research on substance abuse programs for alcohol and other drugs have failed to identify any single "magic bullet" that will be effective in preventing or treating substance abuse (Goplerud, 1992; Ross and Gendreau, 1982). No single substance abuse program has been demonstrated to be superior to others. This does not mean that all programs are equally effective. Rather it means that no single approach is best suited for the multiple needs of the Canadian population. Reviews of the prevention literature indicate that effective programs are more likely to be those that include some degree of targeting appropriate groups in the general population (Goplerud, 1992). More specifically, the evidence points to a multi-faceted, targeted approach as being the most effective (see, for example, Perry et al, 1996).

Since the 1970s, the majority of traditional prevention programs targeted general populations. Programs that target the general population are typically oriented at primary prevention. Primary prevention targets individuals who are not yet at risk (i.e. have not initiated use), or, as is the case for moderate drinkers, are at low risk. CDS Phase II was marked by a shift towards high risk populations as opposed to the general Canadian population. This shift in target populations was accompanied by a shift in emphasis from primary to secondary prevention services. Secondary prevention is aimed at people who are at risk for substance abuse or who have experienced some harm or negative consequences associated with substance abuse (Mann et al., 1995).

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[95] In 1992, it was estimated that 1,600 persons lost their lives in alcohol-related motor vehicle crashes in Canada (Health Canada, 1994e).

[96] Unfortunately, this document was not available during the conduct of this literature review.

The practice of targeting resources at high risk populations is designed to enhance outcome effectiveness and improve cost efficiency. In other words, programs that are directed at those individuals who are at a higher probability for developing substance abuse problems are more likely to benefit from interventions that are tailored to their specific needs (Miller and Hester, 1986).

The notion of developing substance abuse services based on a "risk and harm continuum" has been adopted in several jurisdictions in addition to Health Canada (Ontario Ministry of Health, 1988; American Society of Addiction Medicine, 1994; National Institute on Alcohol Abuse and Alcoholism, 1994). According to the risk and harm continuum model, client characteristics (e.g. severity of abuse) are matched to varying levels of program intensity (e.g. primary, secondary, tertiary).[97] The concept of matching is closely aligned with programs that adopt cognitive-behavioural intervention approaches. Similar to CDS Phase II, matching is designed to enhance program effectiveness and cost efficiency (Ontario Ministry of Health, 1988).

Overall, the transition from CDS Phase I to CDS Phase II was marked by a shift in emphasis away from a general model that targets primary prevention at the entire population and towards a "risk continuum" model that targets secondary prevention at designated high risk populations. In general, the literature review demonstrates that some of those in high risk populations continue to experience substance abuse problems that require intervention (e.g. Single et al., 1994).

We note that Health Canada has adopted a Framework on Population Health that focuses on the determinants of health (social, economic and physical environmental factors; personal health practices, individual capacities and coping skills and health services) (Health Canada 1994f). While this framework appears compatible with current substance abuse prevention models and practices, we did not identify any further literature that directly addresses substance abuse issues in relation to this framework.

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[97] Tertiary prevention is directed towards individuals whose excessive use of substances has created serious difficulties (e.g. health, legal, family problems). This approach comprises alcohol and drug treatment programs. See Robert Mann, "Does Targeted Prevention Work? Evidence from Recent Trends in Alcohol Problems in Ontario," Journal of Alcohol and Drug Education, 1995, 41.

2. Harm Reduction

The modern application of harm reduction can be traced to the 1980s and 1990s. The main goal of harm reduction is to reduce the negative consequences of drug use as opposed to the traditional approach to reduce the prevalence of drug use (Riley, 1992). According to the risk/harm reduction model, as substance abuse problems increase, referral to increasing levels of intensive services are required (ranging from primary, secondary, to tertiary services). In general, the risk for, and scope of problems increases with the quantity and frequency of use and the overall pattern of use (e.g. binge drinking).

Health Canada supports the broad interpretation of harm reduction to include the prevention of use by non-users (abstinence), to the management of risk of harm (for users and non-users) (Health Canada, 1994g). Health Canada recognizes but does not condone that some individuals will use and abuse illicit drugs.

There is a tremendous range of prevention and treatment services that are delivered according to the concept of harm reduction. These services include: needle exchange programs, methadone maintenance, moderate drinking techniques, server interventions, and educational programs. It should be noted that Health Canada does not support all the approaches that are included in the harm reduction model (e.g. support for the legalization of illicit drugs) (Health Canada, 1994g).

In recent years, Canada has experienced an increasing shift towards using a harm reduction approach to deal with substance abuse problems.[98] The entire foundation of CDS is based on a harm reduction strategy. The primary objective of CDS is to make Canada's alcohol and drug interventions more effective at reducing harm to individuals, families, and communities caused by problem alcohol and other drug use. Outside of CDS, there appears to be a steady application of harm reduction strategies in several jurisdictions (e.g. Addiction Research Foundation, 1993b; Ontario Ministry of Health, 1988; Donwood Institute of Toronto). Harm reduction strategies are often associated with programs that produce positive outcome results that are not narrowly defined in terms of control (abstinence) or lack of control (e.g. controlled drinking) (Eliany and Rush, 1992).

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[98] It should noted that harm reduction has its widest application in countries outside of Canada and the United States (e.g. Britain). Refer to the Addiction Research Foundation, A New Approach to Alcohol and Drug Problems: Best Advice Paper. (1993).

E. Status of Outcome Evaluations on General and High Risk Populations

The current report focuses on the research literature on prevention programs as specifically applied to the five high risk populations identified in CDS Phase II. The literature search focuses on Canadian and international prevention studies (primarily the United States) in order to elaborate on the high risk groups. The literature review focuses on research published over the past five years in the area of outcome evaluations.

Since the 1990s, the field of substance abuse prevention research has been described as in its infancy (Botvin, 1990). The Office of National Drug Control Policy in Washington D.C. recently reported that "no strategy or approach has yet been proven through rigorous scientific study to be effective over the long term in reducing substance abuse" (1993).[99] In Canada, researchers have noted that there is a need for more evaluation studies in the area of prevention programs that target high risk populations (Eliany and Rush, 1992).

Despite these findings, it should be noted that some research findings do exist in the area of prevention programming for high risk populations. In fact, there is limited evidence that suggests that multi-faceted prevention programs targeted at high risk populations in Canada and the United States have resulted in some positive outcomes (Eliany and Rush, 1992; Office of Substance Abuse Prevention, 1993, Perry et al, 1996).

1. Out-of-the-Mainstream Youth

There appears to be an absence of systematic and well controlled evaluations that measure the effectiveness of interventions for out-of-the-mainstream youth in Canada (Caputo et al., 1996). Developing a suitable methodological design for high risk youth is somewhat problematic due to the transient nature of the population and the diverse range of services that are offered across the country. A recent review of runaways and street youth in Canada reported that despite limited evidence for effectiveness, further research is required to properly assess the validity of the outcome results for this population (Caputo, et al., 1996).

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[99] Consequently, it has been pointed out that more is known about what doesn't work in substance abuse prevention than what does (due to the general lack of a solid scientific base). Refer to the Office of the National Drug Control Policy, Substance Abuse Prevention: What Works and Why. Washington, D.C.: Center for Substance Abuse Prevention, 1993.

2. Women

Prevention programs that are targeted at women have focused on a number of areas, including: women and pregnancy; women and the use/misuse of medications; women who use tranquilizers and alcohol; and specific groups of women, such as elderly women and immigrant women. In recent years, a fair amount of research has been directed at prevention programming for pregnant women.

It was previously noted that there is a high incidence of FAS/FAE in several regions of Canada that demands a response in terms of substance abuse prevention and treatment services (Single et al.1994, Schorling et al., 1992) . A 1992 CDS baseline report on the effectiveness of alcohol and other drug prevention and treatment programs examined the evaluation data on pregnant women whose children run the risk of fetal alcohol syndrome (Eliany and Rush, 1992). This review of evaluation data included a number of prevention programs in Canada and the United States. The 1992 CDS baseline report summarized the evaluation data on prevention programs targeting pregnant women as generally effective (Eliany and Rush, 1992).

Research that has followed the 1992 baseline report tends to support the observation that prevention services targeted at pregnant women are effective. Educational and counselling initiatives have demonstrated success in terms of increasing knowledge about the health risk associated with pregnancy but have not resulted in clear behavioural changes. For example, a media campaign in Manitoba produced increased awareness about the risks associated with drinking during pregnancy among a sample of three thousand respondents (Casiro et al., 1994). Alternatively, a cognitive-behavioural prevention program delivered to economically disadvantaged women in the United States produced positive outcome results in terms of behaviour change (Reynolds, et al., 1995). The evaluation of this cognitive-behavioural program went on to identify matching results in terms of best outcomes among light drinkers, African Americans, and non-Protestants.[100] Overall, prevention programs targeted at pregnant women have produced some positive outcomes. Since FAS is largely linked to heavy drinking behaviour, access to appropriate treatment services for women with alcohol-related problems who become pregnant, is clearly a need.

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[100] The finding regarding light drinkers should be viewed with caution given that the evidence does not support a strong linkage between this group and FAS. Clinical studies indicate that heavy maternal drinking (consistent with alcohol dependency) is closely linked to Fetal Alcohol Syndrome (Plant et al., 1993). These findings tend to suggest that comprehensive assessment and matching into appropriate interventions are required for women who are at risk of experiencing FAS.

3. Seniors

The risk factors associated with substance abuse among seniors is fairly well documented in Canada (Health Canada, 1995b). The pattern of substance abuse linked to the aging process, including the misuse of prescription drugs, is a major health issue for seniors. There is an absence, however, of well-controlled outcome evaluations that measures the effectiveness of prevention programs for seniors.

4. Aboriginal Peoples

Since the initiation CDS Phase II, there has been a comprehensive training strategy directed at aboriginal peoples in community development and program evaluation. Health Canada sponsors training events for aboriginal peoples in order to develop the abilities of health and social service providers to evaluate the effectiveness of aboriginal prevention programming. The results from these efforts should produce findings on what types of interventions work and for whom. To date, the research literature does not reveal systematic evaluations on the outcome effectiveness for prevention services directed at aboriginal peoples.

5. DWI

Despite some positive outcomes, there are mixed findings for prevention services that are directed at impaired drivers (Eliany and Rush, 1992).

There are examples of recent studies that have found positive outcomes for prevention directed at impaired drivers. For example, researchers recently examined the performance of impaired drivers who were placed on probation and court-referred to participate in driving while intoxicated (DWI) education programs (Jamieson and Stone, 1991). In comparison to the recidivism level of 35% for offenders who did not receive the DWI training, the researchers found that of the 331 participants who completed the education programs, only 10% were rearrested for DWI within a 2-year follow-up[101]. Moreover, some evidence was available to suggest that program success could be predicted based upon the offenders' attitude toward change.

Most evaluations indicate that prevention services have an impact on attitudes and knowledge as opposed to positive behaviour change (Eliany and Rush, 1992). For example, researchers randomly assigned drinking drivers with multiple offenses to either an educational program or a control group (Vingilis et al., 1981). Compared to the control group, the educational group showed significant increases in knowledge and attitudes scores between pre- and post-test administration. However, after 3.5 years, no differences existed between the two groups on traffic safety measures. A persistent concern is thus with repeat offenders whose behaviour does not change despite their participation prevention-oriented activities.

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[101] Recidivism rates, as an indicator of program effectiveness, should be noted with the caution that they only reflect the relative effectiveness of formal apprehension by law enforcement officials, not actual drinking driver behaviour rates.

E. Continuing Challenges

1. On-going Need for Outcome Evaluation Research

The major gap that was identified in the current literature review is linked to the area of prevention and program evaluation. Further effort should be directed at expanding a knowledge base on the effectiveness of prevention services that are directed at high risk populations, and include gender-based analysis as appropriate. In particular, outcome-oriented research directed at out-of-the-mainstream youth, seniors and aboriginal peoples is still needed.

The research literature indicates that significant gains can be achieved through properly matching individuals within high risk populations to appropriate types of intervention (e.g. primary, secondary, tertiary). For example, the results from recent program evaluations on impaired drivers indicates that individuals with specific types of client characteristics derive increased benefits from this intervention (Eliany and Rush, 1992). Targeting client characteristics (e.g. severity of abuse among impaired drivers) can lead to improved cost efficiency and effectiveness. The evaluation literature also highlights the importance of targeting different types of outcomes based on a given intervention (e.g. knowledge, attitude or behaviour changes).

2. Survey/Trend Data

Prior to 1992, there was extreme unevenness in the amount and kind of information available on high risk populations in Canada (Single et al., 1994). There have been good gains in developing a database on high risk populations in Canada since 1992, however, there is still a requirement to build onto that information base. The Horizons 1994 report contributed to the information base by examining a wide range of data sources (i.e. national and regional) in order to elaborate on the substance use patterns of high risk populations in all the provinces and territories of Canada. Canada's Alcohol and Other Drugs Survey made a further contribution to the information base by collecting representative national data on several high risk groups (e.g. women, seniors, impaired drivers). The second version of the CADS will add to the information base on aboriginal peoples in the Northwest Territories and the Yukon. In the upcoming years, the challenge is to develop data collection methods that can cover the existing gaps in hard to reach populations, such as out-of-the-mainstream youth and aboriginal peoples. Similar to the second version of the CADS, a combination of quantitative and qualitative data collection techniques is required to more fully examine Canada's hard-to-reach high risk populations.

IV. CONCLUSION

The literature review uncovered a number findings in relation to the decision to shift Canada's Drug Strategy away from the general population and towards high risk populations. The improvements to the knowledge base (e.g. CADS) on high risk populations has been accompanied by the development and implementation of a wide range of secondary prevention services. The research literature on program effectiveness consistently highlights the importance of tailoring prevention services to the specific needs of these high risk groups.

The evidence of program effectiveness among several high risk groups (e.g. women and FAS and impaired drivers) suggests that cost efficiency and positive outcomes are linked to targeting high risk groups. There still remains a requirement, however, to examine the evaluation results on all of the high risk populations in order to assess the success of the overall strategy. There is a lack of evaluation studies on certain high risk groups (e.g. out-of-the-mainstream youth, seniors and aboriginal peoples) that must be developed in order to assess the effectiveness of the existing prevention services.

Despite the advances in creating an information base on high risk populations, there is still a challenge in developing innovative methods for collecting information on all of the high risk populations identified in CDS Phase II. The current trends indicate that prevention services must address socio-demographic patterns associated with each of the high risk groups. For example, prevention services must address the abuse patterns among seniors (e.g. prescription drugs and alcohol) and the predicted rapid growth in the population of older Canadians in the next few decades. The research literature indicates that effective program development is dependant on accurate information about the specific patterns of abuse among the high risk populations. Continued emphasis should therefore be placed on improving the knowledge base on the high risk populations and linking these findings to program development and implementation.

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PART III: INTERVIEWS WITH EXTERNAL PARTNERS

Final Report

December 18, 1996

Jamieson, Beals, Lalonde and Associate, Inc.

I. INTRODUCTION

This report presents the findings of our interviews with Health Canada's external, non-federal partners. These interviews have provided us with a range of opinions concerning the effectiveness of the Health Canada component of the CDS. As well, they have provided a context for, and clarification of, various topics raised in our Document Review Report. The report contains a limited, preliminary analysis of these interviews. Our next report, focussing on interviews with Health Canada staff and its federal partners, will be presented in a similar format. The findings contained in the Interview Reports will be analyzed along with the Document Review Report and Literature Review in the next stage of our evaluation. The findings, conclusions and recommendations of that stage will then be represented in one, final report.

II. METHODOLOGY

Potential interviewees were selected in consultation with the Project Authority and key Health Canada CDS staff. In several instances, the designated telephone interviewee was joined by a colleague. Others recommended additional contacts. Some of these were subsequently added to our list. The following chart indicates the type of organization and number of interviews carried out.

External (non-federal) Partner Interviews

Type of Organizations	# Contacted	# of Interviewees
Provincially-based Organizations	5	6
Aboriginal & Inuit Organizations	2	1
Academics & Other Subject Matter Experts	3	3
NGOs	1	1
Law Enforcement Associations	1	1
International Organizations	4	4
CDS Youth Project Funding Recipients	5	8
CDS Aboriginal Project Funding Recipients	3	3
Total	23	27

Taken together, the interviewees represented a wide range of experience and expertise on CDS related issues. The bulk of the interviews were conducted by telephone, and ranged from 1-2 hours (and in several cases, more). We appreciate the considerable time that interviewees invested in the evaluation. We note that many expressed interest in receiving a copy of the final report[102].

Our interview guide and list of interviewees is included in the Appendices to this report. Many of the questions paralleled the questions posed to federal officials (with the notable exception of detailed questions on the organizations/internal workings of the CDS).

III. FINDINGS

The interview guide was organized according to topics raised in the Interview Guide (these generally correspond to the evaluation questions we'll be addressing in the final report). Consequently we have organized our findings in this same format. In most cases, there was a high degree of consensus of opinion among all the interviewee groups. We have noted differences where relevant.

A. ORIENTATION (Q1)

The majority of interviewees had some familiarity with the Health Component of the CDS Phase II. The nature of their involvement, and knowledge of the CDS Phase II differed. Funded recipients, for example, were mostly aware of the CDS Phase II in the context of their project, and the funding they had received. Subject matter experts, provincial contacts, and representatives of professional associations were more familiar with the overall contours of the CDS Phase II. One interviewee was not at all familiar with the CDS Phase II.

B. INTENTIONS/ACHIEVEMENTS OF THE CDS (Q2)

Intended Strategies to Enhance Programming

Very few of the interviewees felt equipped to comment in detail on this topic, because they were unfamiliar with the specific details of the strategy, and, in some cases, were unclear on the boundaries of the Health Canada component of the CDS versus the entire strategy, and versus other federal strategies, such as the AIDS and the Tobacco Demand Reduction Strategy. There was a general awareness that CDS comprised a new focus on high risk populations, versus mainstream programming in the prevention area. There was limited awareness of Health Canada's role in enforcement and control.

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[102] Interviewees were referred to the Project Authority for information regarding dissemination of the final report.

Has the CDS Phase II Strengthened Programming?

Few interviewees felt equipped to comment in detail on this topic. Many did note that conceptually, a coordinated blend of prevention, enforcement, and control strategies was, and still is, a relevant and appropriate approach to address drug-related issues in Canada. The majority of the provincially-based organizations were more familiar than other interviewees with the strategic thrusts of the CDS Phase II. Most stated that the orientation of Phase II was a logical extension of the work in Phase I and that prevention programming had been strengthened.

Accomplishments under the CDS Phase II

Several believe that improvements have been seen, particularly in the areas of prevention, coordination, and mobilizing the substance abuse community.

One interviewee felt that CDS Phase II has provided a forum for discussion, national direction, and coherent policy-building. Several interviewees noted that internationally, the CDS Phase II has given Canada a good national profile, particularly in comparison to the American profile based on the "War on Drugs" approach. One interviewee noted that the CDS model is considered the most comprehensive and integrated model available on an international level.

Overall, there was agreement that CDS Phase II had contributed to improved coordination, knowledge-building, and information-sharing. Others noted that it is difficult to attribute changes in programming, coordination, knowledge-building and information-sharing directly to the CDS.

Two interviewees noted that CDS Phase II had strengthened some types of prevention programming via targeting, but expressed concern that this had occurred at the cost of diminished attention to mainstream prevention and treatment.

C. TARGETING (Q3 - Q8)

At-Risk Populations Identified

Most interviewees were able to name the CDS target groups - especially out-of-the-mainstream youth, women, and aboriginal peoples, and, to a lesser extent, DWIs (driving while impaired) and seniors.

Intended Shift

All of the interviews indicated that the rationale for the shift from general population programming to high risk population programming that occurred between CDS Phase I and Phase II emerged from a need to focus on sub-populations that represent a large percentage of the problem, in terms of actual consumption and its harmful consequences.

Several interviewees indicated that targeting was the product of a consultation process. Most others were relatively unaware of how the particular target groups had been chosen.

Two interviewees expressed concern about how target groups were defined in the CDS. One of these interviewees suggested that the target groups were too broadly defined (especially seniors and women, who comprise a significant proportion of the population). Another intimated that targeting has been too influenced by "political correctness" rather than actual risk factors. Both suggested that high risk groups should be more narrowly defined, and based on specific criteria for problems with alcohol and other drugs.

A small number of interviewees questioned the appropriateness of nationally-defined targets groups. While there was acceptance that target-specific programs are helpful, they suggested that national priorities may not be consistent with provincial and/or community-driven priorities.

Shift Made

Interviewees noted that a shift in targeting had occurred, but were unable to provide specific evidence regarding the extent of the shift, beyond their own experience with certain target-group populations.

The Effectiveness of Targeting

Many believe that targeting is a cost-effective way to address the problem, however were unable to provide concrete evidence that CDS Phase II targeting was effective in terms of implementation or outcome.

On-going Relevancy of Target Groups & Strategies

While most interviewees believe that the CDS target groups remain a relevant focus, a small number of interviewees identified other target groups as possible additional priorities. Namely: "problem-drinkers", at-risk, in-school youth, injection drug users (due to health risks/costs), and parents. Two interviewees suggested that a focus on problem behaviours (e.g. drinking, solvent abuse, systemic issues that foster multiple prescriptions, multicultural issues) rather than on target populations per se, would be more appropriate.

What we have Learned

Interviewees stated that programming targets had helped to fill an important gap by providing high risk populations with programs geared to their special needs. Interviewees identified increased knowledge of the needs of high risk populations, which in turn has led to improved program design and delivery, as key outcomes of the targeted approach.

Additional Concerns Raised

Several interviewees indicated a certain uneasiness about how CDS Phase II targeting now fits into Health Canada's Population Health Model. It was stated that conceptually, the Population Health Model can help to look at how substance use and abuse relates to the overall context of health. At the same time, there was concern that substance abuse issues need to be addressed more directly and practically than the Population Health Model appears to allow.

Two interviewees expressed concern about aboriginal programs. One questioned whether the program infrastructure is there for quality program development, quality control, effectiveness evaluation. Another questioned the appropriateness of programming in the absence of a systemic approach to community-development and self-government issues.

D. COORDINATION (Q9 - Q14)

Expectations and Role of Health Canada

Most interviewees did not have any specific expectations of coordination or cooperation at the outset and were unaware of the intricacies of coordination and cooperation at the federal level.

Improvements to, and Level of Satisfaction with Coordination

The majority of interviewees had established positive relationships with Health Canada national and/or regional staff (through funded projects, joint initiatives, meetings, forums, etc.).

Overall, most interviewees who were involved at the program level (or had subject matter expertise in the area) were very to highly satisfied with the coordination and cooperation they experienced via the CDS Phase II.

Provincially, there appears to have been some confusion about the CDS Phase II coordination and communication channels (i.e. the Secretariat versus Program areas), but on the whole, coordination and cooperation with both the Secretariat and Program areas of Health Canada were found to be very to highly satisfactory. One interviewee lauded Health Canada's actions that involved client groups in the planning.

At the international level, two interviewees noted substantial evidence of improved coordination through international meetings. However, two other interviewees stated that Canada has not adequately circulated their reports internationally. It was also noted that Canada did not fulfil a UNDCP request for information (e.g. an annual survey of member states). International interviewees' satisfaction levels with coordination thus varied from very satisfied to not satisfied.

Is Coordination Still Needed?

All interviewees stressed that on-going coordination is required and vital, even if the CDS is not renewed. The preferred route for most interviewees is to have coordination and facilitation occurring at the federal level (within Health Canada). Several suggested "arms-length" alternatives to Health Canada (for example, the Canadian Centre on Substance Abuse). "Arms-length" coordination was mentioned as a pre-requisite to greater credibility in the aboriginal community.

Impact of Non-Renewal

The vast majority of interviewees stated that non-renewal of the CDS Phase II would lead to a loss of impetus now achieved.

E. INFORMATION BASE (Q15 - Q19)

Improvements to Information Development

Most interviewees felt they knew little about Health Canada's intentions in this area, and were unable to provide detailed comment.

Impact on the Knowledge Base

At a general level, most interviewees reported that since CDS Phase II, there was much more information available within their own field, but didn't know how much, if any, was attributable to the CDS Phase II. It was noted that many of the CDS Phase II reports are only now being released. Those who were more familiar with CDS Phase II information products stated that CDS Phase II had resulted in information gains in all target group areas. CDS Phase II-funded national surveys, and the CCSA cost estimate study, were consistently cited as the most notable achievements. To most interviewees, these studies exemplify the kinds of efforts that put Canada in the forefront of the global response to drug issues, are politically relevant, and point to other research priorities. These kinds of efforts are difficult to achieve on anything other than a national basis.

Several interviewees stated that the Canadian Centre on Substance Abuse is a key resource that has improved information accessibility in a variety of ways: publications, on-line services, discussions and meetings. Although the CCSA Internet efforts are noteworthy, one interviewee injected a note of caution regarding accessibility of this kind of electronic service to all Canadians.

Information Gaps

Interviewees did, however, comment on information gaps that still exist. While no one felt there were any dramatic gaps, a number of interviewees stated that CDS research and programming activities had pointed to a number of information priorities that need to be addressed in the future, that will have an impact on policies and programming. These are listed below:

- abuse of licit drugs

- the relationship between and consequences of alcohol abuse and violence
- the costs of drug-related crime
- on-site studies (including case studies and other innovative methodologies) regarding marginal populations
- practical research, on what can be done at the very local level to address substance abuse problems (e.g. the development and evaluation of municipal policies regarding alcohol)
- research on the dynamics and use of drugs among youth generally
- conceptual and practical studies examining the population health model and its application to substance abuse issues
- national trend studies of the dynamics and usage of emerging street drugs (e.g. through emergency room surveys)
- studies focusing on harm reduction policies and strategies.

What/How Information was Disseminated and to Whom?

Interviewees were not able to make direct links between information gathered or produced by CDS and Health Canada programming, per se. Nor were they able to comment significantly on how information developed under the CDS Phase II has been used, or by whom. Nonetheless, most interviewees implied that, since the CDS Phase II, more information has become available (although they do not know if this is attributable to the CDS Phase II).

F. RESOURCES (Q20 - Q25)

Health Canada's Use of Resources

Interviewees were generally unaware of how the CDS Phase II resources were divided between demand reduction and supply reduction activities and were not familiar with how CDS Phase II resources were actually used, or whether they were cost effective.

Funding recipients indicated their CDS projects would not have been implemented if CDS funding had not been received.

Impact of Non-Renewal

Interviewees stated that non-renewal of the Health Canada component of the CDS will significantly impact the sustainability of Canada's response to drug issues. Interviewees identified the following negative impacts:

- non-renewal will result in an absence of a national focus on drug-related issues; there is concern that within a health population model, substance abuse issues will not be accorded the priority (or resources) they should have; cuts to provincial health and social services will further diminish the presence of substance abuse programming.

- non-renewal will result in an unfavourable imbalance among prevention, enforcement and control strategies, because prevention work will be curtailed.

- the accomplishments of the CDS, in the area of coordination, will not be sustained; opportunities for collaboration will be lost because there will be no one to facilitate such action (this includes coordination/cooperation across sectors, at F/P/T levels, and internationally).

- prevention programming for the CDS Phase II designated high risk populations will either diminish or become inaccessible within a Population Health Model, because there will not be the resources to support programming.

- the knowledge gains associated with the CDS will not be maintained over time (this includes concerns over the loss of national trend data).

- closure of the CCSA would be a substantial loss to knowledge-building, information-sharing and coordination.

- Canada's international credibility on substance abuse matters will suffer. For example, Canada has been instrumental in building agreement among United Nations' member states to develop a declaration on the principles of prevention. Without the CDS (which is seen as synonymous with an articulated position on drug issues), Canada's leadership role will be undermined. In other arenas (vis-a-vis the Organization of American States, for example) Canada will be perceived as shirking its international responsibilities and commitments to contribute to the implementation of a comprehensive, balanced response to drug issues.

Several interviewees expressed concern about the impact of sunsetting programs and the feeling of "betrayal" when resources are not renewed. Project recipients in particular stated it is increasingly difficult to cope with the raised expectations that initiatives create, and the reality that they are time-limited, short-term measures. There is a concern that such initiatives lack realism in terms of how long it takes to build a programming infrastructure. One interviewee expressed concern that the quality of program development and delivery may suffer, because project evaluations usually attached to federal funding, will not occur.

Alternatives

Interviewees were not able to identify any viable alternatives to the CDS funding. It was noted that resource constraints are a reality at all levels of government, and it will be difficult for any other entity to assume the work of the CDS. Private sector funding or partnerships were not identified as an alternative funding source.

TECHNICAL APPENDIX - EXTERNAL PARTNER INTERVIEWS

A. External partner interview list

B. External partner interview guide

A. External Partner Interview List

Phil Arbing
Provincial Advisor Corrections and Criminal Justice
Health and Community Services Agency
Charlottetown, P.E.I.

Ryan Aubichon
YES (Youth Empowerment and Success)
Whitehorse, Yukon Territories

Andrew Ball
Medical Officer
Programme on Substance Abuse
World Health Organization
Geneva, Switzerland

Ms. April Barry
Director
Health Promotion
Saskatchewan Health
Regina, Saskatchewan

Mr. Len Blumenthal
Chief Executive Officer
Alberta Alcohol and Drug Abuse
Commission
Edmonton, Alberta

Sharren Breen
YES (Youth Empowerment and Success)
Whitehorse, Yukon Territories

Tullio Caputo
Professor
Department of Sociology-Anthropology
Carleton University
Ottawa, Ontario

Virginia Carver
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B. External Partner Interview Guide

CANADA'S DRUG STRATEGY, PHASE II
HEALTH CANADA COMPONENT
Final Evaluation

Introduction

Interviewers will provide the following background information before commencing the interview:

The Canada Drug Strategy is a 5-year, interdepartmental initiative which began in 1992 and ends March 31, 1997. It builds on the work of its predecessor Initiative, the National Drug Strategy, that began in 1987 and ended in 1992.

The CDS Phase II is designed to improve the effectiveness of Canada's substance abuse programming. *It was to do so by enhancing coordination, improving the knowledge base for making program and policy decisions, and targeting resources to sub-populations at higher risk for substance abuse, and supplementing program resources.*

Health Canada has served as the lead department in this Initiative. Our firm, Jamieson Beals Lalonde, has been contracted to evaluate the effectiveness of the CDS Phase II in strengthening prevention and enforcment and control programming. We're concentrating on Health Canada's role in enhancing programs through improved targeting, enhancing coordination at all levels, and improving the knowledge base on substance abuse issues.

Before we start our interview, I'd like to assure you that your interview is confidential, and you will not be identified individually in the report.

Orientation

1. How familiar are you with the CDS Phase II? What has been your role in, and involvement with the CDS Phase II?

CDS Intentions/Achievements

2. In your opinion, has prevention/enforcement/control programming in Canada actually been strengthened under CDS Phase II? (Were these strategies appropriate? Are they still relevant?)

Targeting

3. One of the strategies for enhancing programming was to target at-risk populations. This was a shift from the original focus on general population programming. What is your understanding of the rationale for such a shift?

4. Given your experience with the CDS Phase II, was the shift to targeting at-risk group(s) actually made? (Give examples/evidence of shift.)

5. Has targeting programs made them more effective? If so, how?

6. Are the current target populations still relevant? If so, are current targeting strategies still appropriate?

7. Are there other targets that are more relevant? If so, why?

8. What have we learned from the shift to targeting at-risk populations?

Coordination

Note: CDS Phase II intended to improve coordination and cooperation at many different levels, including within Health Canada, across Federal Departments, and with other partners, and between prevention and enforcement/control programs and policies. In this interview, however, we are asking specifically about coordination/cooperation between Health Canada and external partners.

9. What did you expect CDS Phase II to achieve in terms of enhanced coordination/cooperation? (What was needed, and at what level?)

10. What role did you expect Health Canada to play in enhancing coordination/cooperation?

11. Are you aware of any improvements to coordination and cooperation that resulted from the CDS Phase II? (i.e.. within Health Canada; with federal partnersWith other government partners (prov/terr); internationally; nationally; regionally; at community levels).

12. How satisfied were you, with the degree of coordination and cooperation achieved?

13. Is on-going coordination and cooperation needed? If so, how should it be accomplished? If not, why not?

14. What would be the impact on non-renewal on coordination/cooperation in this field?

Information Base

The CDS Phase II was intended to improve Canada's information base on drug-related issues.

15. Are you aware of any improvements to the collection and or dissemination of information under CDS Phase II? (Please address both data collection and/or other types of information enhancement activities, and distinguish between traditional and non-traditional information collection/dissemination strategies).

16. How have these improvements increased what we know about the following areas:

    i. Risk factors re: substance abuse.
    ii. At-risk populations (Children, Youth, Young Adults, Out of the Mainstream Youth, Women, Seniors, Off-Reserve Aboriginal people,People at risk of Driving While Impaired (first and subsequent offenders).
    iii. Patterns/trends re: alcohol and other drug use in Canada
    iv. Assessing harm and costs of alcohol and drug use
    v. Resiliency factors.
    vi. Other

17. What significant information gaps remain?

18. Do you know how information developed under CDS Phase II has been used and by whom? (Examples may include development and/or changes to protocols, policy statements, regulations, laws, practise, types of projects proposed/funded, programs developed.)

19. What have been the obstacles (if any) to positive impacts from enhanced information? (Examples may include timing of information collection, dissemination problems, lack of clarity, timeliness, relevancy of information, etc.)

Resources

20. Are you aware of how Health Canada's CDS Phase II resources were used? (Please comment, if possible, on the allocation of resources between specific at-risk groups, activity areas, and prevention/enforcement/control programming.)

21. If you received resources under CDS Phase II, what did the increased resources enable you to achieve, that you wouldn't have been able to do otherwise?

22. Has CDS Phase II made programs more cost-effective than they were in Phase I? If so, how?

23. Were you affected by cuts to CDS Phase II resources? (If so, how?)

24. What would be the impact of non-renewal of CDS Phase II resources?

25. What are the alternatives to CDS Phase II resources?

PART IV: INTERVIEWS WITH HEALTH CANADA OFFICIALS AND FEDERAL PARTNERS REPORT

Final Report

December 18, 1996

Jamieson, Beals, Lalonde and Associates, Inc.

I. INTRODUCTION

This report presents the findings of our interviews with Health Canada officials and selected federal partners associated with the Canada Drug Strategy (CDS) Phase II. The purpose of these interviews was to solicit opinion on the effectiveness of the Health Canada component of the CDS Phase II. In some cases, the interviews also provided us with further clarification of various topics raised in our Document Review Report.

The following report provides a summary of the main interview findings, and is a companion report to the Interviews with External Partners Report. It contains only a limited, preliminary analysis of the findings. These two reports, in conjunction with the Document Review Report and the Literature Review, comprise the field work for this evaluation. Our next step is to analyze all field work reports and to prepare our findings, conclusions and recommendations into one final, evaluation report.

II. METHODOLOGY

We selected potential interviewees in consultation with the Project Authority and key Health Canada CDS Phase II staff. Some minor modifications to our initial list were made: one individual was dropped because they stated that their involvement with CDS had been low, and another individual was dropped due to interview scheduling difficulties. A summary of interviewees is provided in the table below.

Health Canada and Federal Partner Interviews

Department or Agency	# Contacted	# of Interviewees
Health Canada Officials[103]	21	23
Treasury Board	1	1
Solicitor General Canada[104]	2	2
Foreign Affairs and International Trade	3	2
Transport Canada	1	1
Canadian Centre for Substance Abuse	1	1
Total	29	30

Taken together, the interviewees represent groups of individuals with a wide range of experience in, and expertise on substance abuse issues generally.

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[103] This figure includes current and former Health Canada officials associated with the CDS as well as ancillary CDS partners or players located within the department.

[104] Includes Ministry Secretariat and RCMP officials.

Several interviews were conducted in person, however most of the interviews were conducted by telephone. They ranged from 1-2 hours in length, with the exception of several cases which went longer. We appreciate the considerable time that interviewees invested in the evaluation.

Our Interview Guide and Interviewee List are included in the Appendices to this report.

III. FINDINGS

The Interview Guide framed our discussions with interviewees. While the majority of interviewees had a firm understanding of the Health Canada component of the CDS Phase II, they were not able to answer all questions, or answer them to the same level of depth.

On balance, however, we are confident that the interviews provide a balanced and credible perspective of the Health Canada component to the CDS Phase II. On most questions, there was a high degree of consensus of opinion in many areas. We have noted significant differences in opinion where relevant.

The Interview Guide dealt with the following topics: orientation, CDS Phase II Intentions/Achievements, Targeting, Coordination, Information Base Development, and Resources. We have organized the findings according to these topic areas, noting the Interview Guide questions that generally fed into the topic discussion.

A. ORIENTATION (Q1)

The majority of the interviewees were very familiar with the Health Component of CDS Phase II, and most had been involved since its inception. The remaining interviewees were moderately familiar with the Health Component of CDS Phase II. Only a few were recent participants in the CDS Phase II. Several officials had also been involved in aspects of CDS Phase I.

The majority of interviewees had some form of direct experience with the CDS Phase II, in areas such as prevention programming, coordination, social marketing, communications, research, information dissemination, education and training, health protection, drug testing, and enforcement.

B. INTENTIONS/ACHIEVEMENTS OF THE HEALTH CANADA COMPONENT OF CDS PHASE II (Q2, Q3,Q4)

Intended Strategies to Enhance Programming

Interviewees indicated the CDS Phase II was primarily designed to enhance programming by targeting high risk populations and improving overall coordination within Health Canada and beyond. To a lesser extent, interviewees identified information base developments and enhancements, (including demographic surveys, monitoring systems, and background information related to prevention and health protection) as a significant CDS Phase II strategy to enhance programming.

The main points with respect to each strategy are summarized below:

- Targeting: CDS Phase I had focused on general population programming; Phase II was to target high-risk groups (out-of-the-mainstream youth, aboriginals, women, seniors[105]). Phase II would use different approaches and techniques to reach these populations (e.g. participative and facilitative approaches at community levels).
- Coordination: Weaknesses in coordination had been identified in CDS Phase I. Phase II was intended to address those weaknesses by improving coordination across sectors, and across jurisdictions. Improved coordination would result in better sharing of best practices, and would avoid duplication of effort.
- Improved Information Base: improved information was discussed mainly in terms of learning more about at-risk populations, and extending the knowledge base generally (for example, improving trend data). The CCSA was intended as a vehicle to develop, coordinate, and disseminate information.

Has the CDS Phase II Strengthened Programming?

Overall, interviewees stated that programming for high-risk populations had been strengthened by the CDS Phase II, however many feel this gain will be short-lived since the CDS is drawing to a close and there are no alternative resources to sustain efforts.

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[105] Several interviewees noted that the Health Canada component did not directly address Driving While Impaired Issues. Instead, it played an influencing/participative role in assisting Transport Canada's activities with this population.

Accomplishments under the CDS Phase II

Interviewees cited the following as primary accomplishments of CDS Phase II:

- increased knowledge, collaboration and synergy between prevention and enforcement sectors: more players from both sectors see the value of working together and have a better understanding of each other's points of view on demand and supply reduction. The Health and Enforcement in Partnership Committee (HEP) is regarded as a particularly sucessful example. Joint meetings (such as the national meeting of Heads of Addictions Agencies and the Chiefs of Police) were also cited as significant accomplishments.

- enhanced community involvement: primarily through funding provided by the Community Support Program and regional activity, the CDS Phase II achieved federal/community partnership in addressing substance abuse issues.

- enhanced development with Aboriginal communities: CDS Phase II activities contributed to Aboriginal community development to address substance abuse issues, especially in relation to youth. A focus on off-reserve communities was also achieved.

- increased use of non-traditional methods to address the needs of hard-to-reach populations: the CDS Phase II target populations frequently required 'non-bureaucratic" approaches. Street youth mentoring projects and the use of alternative sites for program delivery were two examples of how CDS Phase II was able to adjust its approaches to address these populations.

- improved knowledge base and information systems: the CDS Phase II research advanced knowledge on high risk populations, advanced basic knowledge, and improved knowledge/networking system.

- increased international recognition and profile for Canada: the CDS Phase II was well-regarded internationally as a model that balanced demand and supply reduction, and that provided exemplary models for working with high-risk populations.

- shifted resources away from unnecessary levels of control over certain licit drugs to focus on other drugs and issues including Methadone, blood issues, vaccines, herbal remedies, etc.

- removed unnecessary levels of control over physicians' use of Methadone in treatment and moved to more flexible system of authorization.

- enhanced networks within and across sectors working directly, and indirectly, on substance abuse issues.

Non-CDS Factors Impacting Positively on CDS Phase II Accomplishments

Interviewees stated that the following non-CDS factors impacted positively on the CDS Phase II.

- two related Health Canada initiatives - the AIDS Strategy and the Seniors Strategy, helped to build momentum and synergy. Direct outputs of collaboration include joint projects, and network-building.
- the general trend of horizontal analysis helped to bring non-CDS players from other departments together with Health Canada (e.g. a project on immigrant women and substance abuse involved Canadian Heritage staff not directly involved in the substance-abuse issues).
- MSB's CDS funding has now become a permanent "envelope' of resources that will be used to continue related programming after CDS Phase II sunsets.

Non-CDS Factors Impacting Negatively on CDS Phase II Accomplishments

Interviewees stated that the following non-CDS factors impacted negatively on the CDS Phase Ii.

- implementation timing: the first year of the CDS was consumed with essential planning and staffing, thereby limiting 'tangible' achievements in the first year. (Interviewees noted that this is a typical scenario when new initiatives are launched; expectations for the first year should be down-scaled to match this reality).
- fiscal uncertainty: the majority of interviewees stated that a series of resource cuts during the life-cycle of CDS Phase II hampered activities. Interestingly, several interviewees felt more positive about resource cuts, stating that as a result, their areas operated more efficiently and that some community projects did a very good job of 'making-do' with less, or pooling resources with others..
- Health Canada's reorganization and shift to a Population Health Model: these two factors, contributed to instability and uncertainty of direction, impacting negatively on CDS Phase II staff morale.

- erosion of FPT activity in substance abuse areas: the dismantling of the Federal/Provincial/Territorial Advisory Committee on Alcohol and Other Drug Problems system impacted negatively on FPT coordination at the official level.

- receding provincial response to substance abuse issues: provincial resource cuts, accompanied by the dismantling of some provincial drug-response infrastructures (e.g. addiction agencies, research capacities) has weakened FPT coordination. Many interviewees stated that the federal government had focussed on high risk populations on the assumption that provinces would continue to address general population needs. Because provincial activity in this area has declined, a new programming gap has been created.

- lack of political and public support for substance abuse programming: interviewees noted that the CDS Phase II was introduced with strong political support but this support rapidly waned. They stated that the CDS Phase II was not championed politically or at senior management levels. Many also stated that, unlike issues such as AIDS, there is not a strong community concern advocating for substance abuse prevention.

C. TARGETING (Q5 - Q 12)

At-Risk Populations Identified

Overall, the interviewees were relatively successful in identifying the CDS target groups, however they did not name them consistently, i.e. some interviewees were able to identify high risk groups in their direct areas of work, but not other high risk groups associated with the strategy. One interviewee specified further target groups including individuals needing methadone treatment, those in needle exchange programs, and children with Attention Deficit Disorder treated with Ritalin.

Intended Shift

Interviewees generally understood the rationale for shifting from general population programming to high risk populations in terms of the need to re-direct scarce resources where the risks and harm caused is the greatest. Some interviewees linked this shift to the results of Phase I research efforts, and on consultations with provinces. Several noted that the shift was made on the understanding that provinces would continue to do general population/primary prevention.

Shift Made

Most of the interviewees stated that the CDS Phase II had, to a certain extent, shifted to the target groups they identified. Within the shift they indicated that:

- OOMY was one of the first priorities launched, and comprised a significant portion of the CDS Phase II work.
- significant shifts in working within Aboriginal populations (in some cases with relatively little resources) were made.
- an emphasis with the seniors population and with women's health has more recently emerged.
- there was relatively little emphasis on Driving While Impaired within Health Canada's activities, outside of coordination/cooperation with Transport Canada, who led efforts to address this population.

Activity Areas

Activity areas varied, due to factors such as the different nature of target groups and the profile and dynamics of substance abuse within those groups; the extent of the knowledge base related to the group, and the overall appropriateness of various activities for reaching those target groups.

Activity areas included:

- social marketing: interviewees stated that social marketing was down-played in CDS Phase II because it was not considered the best strategy for reaching certain high risk populations such as OOMY, Aboriginal populations.
- education and training: traditional activities (i.e. those occurring in school settings) also diminished in CDS Phase II in favour of alternative strategies, such as for OOMY and other populations, including: peer counselling, community action pack training, aboriginal youth networks, and self-help materials.
- research and information gathering: this activity varied by target populations: with OOMY, basic research was conducted to inform program development; with Aboriginal populations, the emphasis was on partnership-building and programming; with women, some basic research was conducted then applied via demonstration projects; with seniors, the emphasis was on knowledge synthesis and dissemination.

- community-based development/funding: a community focus on programming was cited as a common activity across all target areas.
- national policy development: national policy development on substance abuse issues was subject matter specific, not targeted to specific groups e.g. harm reduction, cannabis, FAS, responses to court rulings on CRTC on advertising, labelling, etc.

The Effectiveness of Targeting

The majority of interviewees were of the opinion that targeting had made Health Canada's programs more effective. Others felt they could not comment usefully on this topic, because they had not seen any evaluation results from CDS Phase II supported programs. Many observed that there is no clear empirical evidence to support program effectiveness at this time. Several interviewees suggested that CDS Phase II resulted in better knowledge of how to address high risk populations, especially within Aboriginal populations.

On-going Relevancy of Target Groups & Strategies

Most interviewees stated that the CDS Phase II target groups are still relevant. Their needs are on-going, and focusing on those most at risk who experience the highest consequence is more cost-effective. Within that context, however, several noted that targeting strategies are bound to change over time.

Only a few interviewees suggested specific additions to target groups. Suggestions included street youth over 25, children primary to Grade 6, and mainstream youth). At a more general level, however, many interviewees expressed concern that primary prevention is being neglected. Several specifically suggested that Health Canada re-balance its efforts between high risk and general population programming. One interviewee suggested that Health Canada could learn more from harm reduction strategies employed in other countries such as the Netherlands. Another suggested that Health Canada needs to re-balance in the larger context of resources dedicated to illicit drugs, and licit drugs, such as tobacco, alcohol and pharmaceuticals.

What we have Learned

Interviewees cited that we have learned the following lessons from CDS Phase II targeting:

- CDS Phase II confirmed that high risk target groups have different needs and therefore require different approaches than the general population.

- the scope of target groups identified in the CDS Phase II varied and were in themselves not homogeneous.
- target groups can be very small numbers within a community, depending on where they are coming from, and how long they've been at risk.
- target group empowerment and participation in program design and development are pre-conditions to successful programming.
- OOMY have the same wants and needs as the rest of population (need love, respect/have ambitions), yet they don't fit our social model (i.e. school system). We must educate society to look beyond their appearance and language.
- the importance of youth involvement and empowerment, and the importance of educating decision-makers to see youth-at-risk as a deserving population.
- there are no short-term, quick-fix solutions to substance abuse.
- building community awareness about high risk populations is part of the solution.
- intersectoral collaboration is key in working with youth.
- communities are very willing to tackle their issues - even with very few resources.
- gender issues cut across all streams; both gender-sensitive and gender-specific materials are needed.

Several interviewees noted that CDS Phase II represented a significant departure from CDS Phase I. In retrospect, they felt that the need for a transition phase between the Phase I general population programming approach and Phase !! should have been recognized.

D. COORDINATION (Q13 - Q24)

Why Improvements to Coordination Needed, and how Coordination Conceived

The majority of interviewees stated that coordination was needed because it:

- was recognized as a weakness in Phase I

- would avoid duplication of effort and services and create a more cohesive and cost-effective strategy across programs
- would enhance information-sharing and build understanding for different perspectives on substance abuse issues, particularly between health and law enforcement sectors
- would shift the corporate cultures within health and law enforcement sectors, away from "territoriality", towards inter-sectoral cooperation and collaboration, and
- would ensure that different levels of government, non-governmental organizations (NGO's), and the community would work together in a unified fashion.

Many interviewees noted that the coordination role of the Canada Drug Strategy Secretariat (CDSS) was not officially defined. From the beginning of the CDS Phase II, it would appear that there were many different views on what the CDSS's role in coordination should have included. There also appears to have been initial confusion on the role of the CDSS vis-à-vis the Canadian Centre on Substance Abuse (CCSA).

Intended Achievements of Coordination

The intended achievements of coordination most frequently cited were:

- improved coordination within Health Canada, across federal departments, and with other levels of government and external partners, and thereby improved responsiveness to substance abuse issues
- broadened knowledge base, better synergy, and thereby better programming, and
- improved balance between supply reduction and demand reduction fields.

Expectations of the CDSS

The majority of interviewees identified inter-departmental coordination as their primary expectation of the CDSS. As noted above, there was no formal rationale or agreement for the CDSS role in coordination. Other expectations associated with the CDSS role included to:

- give national focus, a common approach and public profile to the CDS Phase II

- identify emerging issues and opportunities for collaboration, and bring interdepartmental players together on issues of mutual concern (e.g. Bill C-8)
- broker/coordinate information flow among players from different levels (e.g. provincial players, etc.)
- have the authority to allocate funds interdepartmentally, including facilitating the setting of annual goals for CDS (and each player), then measuring progress and reallocating funds as necessary.

Within Health Canada, the interviewees had varying expectations of the CDSS, including to:

- act as a departmental coordination and liaison body (eg. with CCSA)
- monitor the "global picture" interdepartmentally, nationally, and internationally
- support regions in their efforts to focus on target groups
- keep the profile of the various parts of Health Canada programming "on a par" with one another within the department and outside the department
- ensure that the other activities of CDS fit with Health Canada goals
- champion the need for an on-going federal substance abuse strategy.

Did the CDSS Have Adequate Resources?

The majority of interviewees thought that the Secretariat had adequate human and financial resources at its disposal for coordination. However, many interviewees restated that the CDSS lacked a clear mandate and authority to coordinate the CDS Phase II, which impeded its work. Several interviewees suggested the CDSS's relatively low level within Health Canada's organization structure further hampered its authority, and consequently credibility, to coordinate the CDS Phase II. Several interviewees noted that the CDSS experienced resource cuts that also impacted on its ability to coordinate effectively.

How was Coordination and Cooperation Operationalized?

With only a few exceptions, most of the interviewees were familiar with the formal and informal mechanisms for coordination associated with the CDS Phase II. The mechanisms were found to be effective to varying degrees, ranging from very effective to fairly effective. Only one interviewee stated the mechanisms were ineffective. Several interviewees were unable to comment on the effectiveness of coordination.

Generally, interviewees appeared to be satisfied with the level of coordination achieved, particularly given the contextual difficulties which surrounded coordination (e.g. lack of mandate, different corporate cultures, resource cuts etc.).

Some interviewees felt that the CDSS had made some strides in coordinating within Health Canada, between law enforcement and prevention sectors (via HEP), and internationally. Several interviewees noted that the CDSS had been able to provide information and expertise to others within the department. Others felt that the CDSS had been more successful in coordinating in areas related to prevention than related to health protection. Committees formed for certain purposes or projects (e.g. at the Health Canada program level) were generally found to be effective.

Criticisms of the CDSS included the view that the CDSS was unable to secure collaboration and understanding between enforcement and prevention, and was unable to successfully link with provinces. Some interviewees felt that CDSS's international activities were unnecessary, and that the CDSS should have focused more on securing the longevity of the national strategy.

Interdepartmentally, some interviewees felt that it was difficult to attain a common understanding of the CDS Phase II among players, that players kept changing, and that the players at the interdepartmental committee was not senior enough to make decisions. This appears to have resulted in frustration on the part of many players. Task-oriented or project oriented mechanisms were cited as more successful.

On several occasions, interviewees stated that the roles of the CDSS and the CCSA in relation to coordination lacked clarity.

What Improvements to Coordination were Achieved?

The following improvements to coordination were noted:

Within Health Canada:

Interviewees cited the following improvements:

Built onto effective practices; better resource activities; better functioning of activities directed to specific areas of expertise; more communication about services available within the field; developed models on how to conduct programming; and increased collaboration on project work.

Two areas of special note were mentioned:

- MSB-HPPB (OAD Unit) collaboration on aboriginal substance abuse issues improved, resulting in better sensitization to the issues, a cross-fertilization of ideas, increased mutual respect, and, ultimately, better program development.
- OAD Unit interaction and coordination with other Health Canada program areas (for example, with the Community Support Program) resulted in better communication, understanding, and program development.
- Cooperation between CDS staff and other initiative staff was characterized as good.

With Federal Partners

As noted earlier, interviewees identified a number of weaknesses with interdepartmental coordination, however interviewees noted that there was better sharing of information and expertise across departments, especially Health Canada/Solicitor General Canada, and FAIT as a result of CDS Phase II.

With Other Governments

F/P/T coordination diminished under Phase II due to decentralization and the disbanding of the FPT Advisory Committee on Substance Abuse. However, some FPT liaison and coordination occurred at regional, program, and project levels. The Canadian Community Epidemiology Network and emergency room data project were two examples of inter-jurisdictional coordination frequently cited.

International

Internationally, Health Canada successfully placed demand reduction on the international agenda. Work performed with international organizations, such as UNDCP, WHO, and OAS has helped to bring a more balanced approach to substance abuse strategies.

National

Interviewees felt that Health Canada's CDS Phase II had specifically improved coordination with national aboriginal organizations on substance abuse issues, particularly with those representing off-reserve populations. Interviewees cited anecdotal evidence of improved coordination with NGOs and professional associations, due to their inclusion in myriad workshops, forums, conferences, etc. Some interviewees felt that Health Canada had contributed to community development/response through the Community Support Program.

Regional

Interviewees noted that Health Canada regional staff worked more closely with their regional counterparts than in Phase I. One regional interviewee stated that the CDS Phase II had broken a lot of ground e.g. they were perceived as resource persons, not just as "funders".

Community

Some interviewees felt that the CDS had helped to train community members in program delivery. Others indicated the difficulty in knowing what was achieved at the community level, as difficulties in tracking the results of programs funded through grants and contributions persist.

Benefits and Downsides of CDS Coordination

The overwhelming majority of interviewees said that coordination had added value. The kinds of benefits cited included:

- inter-departmental/intersectoral relationships with potential sustainability
- shared expertise and ideas on how to approach supply and demand reduction
- cost-efficiencies through shared information and collaboration, thereby avoiding duplication and "reinventing the wheel.
- learning opportunities within and across sectors and regions and communities.

Interviewees were asked to comment on any downsides of CDS coordination. Many of the comments seem to refer to weaknesses in the strategy itself, rather than to coordination. For example:

- loss of authority within division that held previous responsibilities before CDS
- lack of coordination at the interdepartmental level (especially health/enforcement), on licit drug use (e.g. diversion of drugs from pharmacies, forged prescriptions, robberies/thefts, etc.)
- occasionally, projects that did not include adequate consultation or collaboration (e.g. between HC prevention programming and BDS staff, on the development of drug-related public information materials; inadequate consultation between NHRDP and BDS on Chinese herbal medicine issues).

Targeting and Collaboration with Other Initiatives

Most of the interviewees stated that CDS had effectively interacted and collaborated with other Health Canada initiatives related to:

- AIDS (injecting drug use, harm reduction)
- Seniors (medication)
- Child Development Initiative (young mothers/FAS)
- Tobacco Demand Reduction Strategy (joint messaging for young girls)

There was good issue-related collaboration on topics such as women's substance abuse, aboriginal substance abuse, family violence, and mental health issues.

Satisfaction with Coordination/Cooperation

Most interviewees stated they were either satisfied or very satisfied with the level of coordination/cooperation that occurred within the CDS Phase II. Several qualified their remarks, adding that coordination had more potential than was, or could be realized, given the problems with the way the coordination infrastructure had been set up within Health Canada, and given the differing and somewhat "entrenched" points of view within prevention and enforcement sectors.

Would Coordination have Happened without the CDS?

The majority of interviewees stated that some aspects of coordination would not have occurred without the CDS Phase II, notably prevention/law enforcement coordination, and project-specific coordination activities. Interviewees were divided in their opinions on whether coordination within Health Canada on substance abuse programming would have occurred without the CDS Phase II. One interviewee suggested that some achievements which occurred under the CDS Phase II, such as Bill C-8, would have occurred without the CDS Phase II.

Is on-going Coordination Needed?

Virtually everyone felt that on-going coordination and cooperation is necessary if the federal government wants to:

- ensure the effectiveness of federal activity on substance abuse
- create new knowledge, attitudes, approaches and support for collaborative work across and within departments.

At the same time, interviewees recognized there must be a funding strategy for substance abuse i.e. something to coordinate. Others suggested that given scarcer resources, it is necessary to re-prioritize and develop new approaches based on what can be done within those constraints - not what's needed overall. Others noted that support of senior management is essential to making coordination work.

All interviewees felt that some form of either federal interdepartmental or departmental committee/working group could maintain on-going coordination. Such a mechanism would need to balance supply and demand reduction, and involve more power-sharing between Health Canada and its federal partners. It was further suggested that:

- an independent, non-programming body could chair such a mechanism
- the group mandated with coordination should also have substantive expertise in substance abuse, and
- community groups could be involved in coordination.

Abolition of the CDSS

The interviewees were generally split between stating that there was no impact from the abolition of the CDSS to detailing various negative impacts as a result of the Secretariat's closing (e.g, loss of expertise, loss of a focal point, lack of awareness of other federal partners' activities). Only one interviewee mentioned re-establishing the Secretariat.

Impact on Non-Renewal of the CDS

Almost all of the interviewees argued that non-renewal of the CDS would have a negative impact on their areas of work in the field of substance abuse prevention/enforcement. Interviewees stemming from enforcement areas endorsed the importance of prevention.

Two interviewees (from health protection and aboriginal substance abuse perspectives) indicated that non-renewal will not significantly impact on coordination in their respective areas.

Common themes concerning the impact of non-renewal include:

- fragmentation of effort (at Health Canada, at the FPT level, and internationally)

- a return to independent approaches within supply and demand reduction spheres
- lack of coordination and loss of opportunities for joint initiatives
- reduced project/program activity, and
- absence of an articulated vision and national leadership, sending an inappropriate message to Canadians about substance abuse problems.

Lines of Authority

Approximately one-third of interviewees were able to comment on the Health Canada lines of authority for the CDS. Four interviewees stated specifically that the lines of authority were not clear. The remainder felt the lines were clear, however there was not much detailed comment on the operation or effectiveness of the lines of authority. A few interviewees felt that there was some confusion in responsibilities, particularly in distinguishing strategic and program-level coordination. Others indicated that the information flow to senior management was ineffective, hampering activity.

E. INFORMATION BASE (Q25-Q35)

Improvements to Information Development

Interviewees noted that:

- information base improvements were primarily directed to high risk groups, including a stronger focus on qualitative research methodologies
- general trend information was improved through quantitative surveys such as NADS
- syntheses of existing research and specific research projects had addressed many aspects of substance abuse issues within high risk populations
- database improvements (e.g. NARCON, CSP project data base).

Interviewees cited many examples of improvements to the information base. Those most commonly cited included:

- the costs of substance abuse study

- NADS
- emergency room data project.

Impact on the Knowledge Base

Most interviewees did not provide a great deal of information on how the knowledge base had increased in specific areas, however the following comments were made:

- risk factors: more is known about the commonalities and differences among high risk groups and the dynamics of risk factors; however, the relative importance of risk factors, and how to intervene to address them, is still in its infancy.
- at-risk populations: more information on the nature of at-risk populations has been created
- patterns and trends: NADS and CADs have improved the information base, but on-going trend data is need.
- assessing harm/costs: the CCSA costs of substance abuse study was noted as a significant advancement in this area.
- resiliency: several interviewees mentioned the Health Canada resiliency study (see Mangham, et al, 1995, cited Part II: Literature Review).

Information Gaps

Interviewees identified a range of information gaps or challenges for the future:

- Aboriginal substance abuse
- motivating forces regarding the abuse and misuse of substances
- effects of treatment modalities (including abstinence); treatment of young mothers, pregnant women and their offspring, criminal offenders
- marijuana use
- generalizable information on what works in terms of prevention (especially secondary prevention)
- trend data and emergency room data - need to continue for on-going relevancy

- patterns of use (i.e. info on how substances are used - when, where, etc.- not just how many users and how much they consume) as basis for developing interventions
- high risk behaviours (e.g. dangerous driving) related to DWI
- the costs of crime associated with substance abuse
- standardized instruments on substance abuse, for international comparison
- the relationship between substance abuse and the population health model
- the abuse of legal drugs, and the impact that has on the health care system.

What/How Information was Disseminated and to Whom?

Interviewees were able to identify a range of information products, including research study reports, literature reviews, drug testing results, fact sheets, etc.

The CCSA was recognized as the key mechanism to disseminate information - in both paper and electronic formats. Most interviewees did not comment in detail on the CCSA's performance in information dissemination, although its use of the Internet was noted by several as an significant step.

Interviewees were of the opinion that the information had been circulated to a wide range of audiences - including community members, other levels of governments and professionals (e.g. addictions workers, police, etc.). They said that anecdotal evidence suggests that CDS Phase II information is being requested and used internationally.

Impact of Information Base

Recognizing it is difficult to attribute specific impacts to the CDS Phase II information given the range of resources available, many interviewees believe that CDS Phase II information networks and products have contributed to policy and program development on substance abuse issues at community, regional, national, and international levels. There were also some examples of cross-fertilization across issues (e.g. substance abuse and AIDS) Some examples of how information impacted policy and programming are:

- inventory of prevention programs for aboriginal people was disseminated to aboriginal communities

- *Truth Heals* document was disseminated through national Aboriginal organizations and was used as a framework document with MSB

- Narcon system information was provided to UN (information is also provided to researchers on request)

- Inter-regional information sharing included a handbook for youth, videos, workbooks (manual on self-help groups for recovering women) distributed by Atlantic region (within region and to other regions)

- A workshop on sustainability (held in partnership with OAD Unit) resulted in 140 copies of the workshop report being distributed to CDS projects in the region, as well as to groups.

Several interviewees noted that time delays in collecting and disseminating information were obstacles. They suggested that forums to share information at earlier stages (e.g. round tables, teleconferencing internet, etc.) could be further exploited. Another interviewee noted some time delays come with the territory of empirical, longitudinal research, which is typically first disseminated through academic forms.

F. RESOURCES (Q36-Q41)

How were resources used?

Overall, interviewees reported that CDS resources were used in a wide range of areas, notably policy and programming activities, research, public awareness/social marketing activities, information development/dissemination, information data base development, network development, and international work.

Interviewees cited a variety of achievements that would not have been possible without CDS Phase II resources, notably:

- most of the prevention programming undertaken in the CDS Phase II would not have happened without the CDS Phase II. The base core funding for substance abuse issues would have only allowed Health Canada to provide content expertise within the department (and to other initiatives or strategies), and to conduct limited studies or policy work.

- research, social marketing, and community projects would not have occurred without CDS Phase II resources.

- with respect to Aboriginal communities, a focus on substance abuse on youth, on-reserve project development, and off-reserve project development (e.g.

solvent[106] abuse studies), would not have occurred without CDS Phase II resources.

- in the health protection area, improvements to information data bases, and linkages/guideline developments with health professionals were enhanced, due to CDS Phase II resources.

Cost-Effectiveness

The majority of interviewees reported they had no 'hard' evidence of cost-effectiveness of CDS Phase II activity because the CDS Phase II did not include a strong evaluation component that was capable of measuring beyond the short-term[107]. Interviewees were unable to comment on the comparative cost-effectiveness of the CDS Phase II versus CDS Phase I, because each Phase had a unique orientation.

Some interviewees did identify areas where, in their opinion, the CDS Phase II had demonstrated cost-effectiveness, namely through:

- increased collaboration within Health Canada, and between Health Canada and other federal departments, which is believed to be more cost-effective than independent action (a few interviewees felt greater cost-efficiencies could have been realized, had they adopted a more horizontal funding approach)
- improved information systems which will eventually lead to better utilization of resources and exchange of information (for example, between health and law enforcement agencies).

On a final note, several interviewees observed that the CDS Phase I was a necessary foundation for the CDS Phase II. To capture the gains of both Phases, what is really needed is a Phase III, that would integrate and build upon the lessons learned from Phases I and II.

Impact of Cuts

Generally, interviewees reported that resource cuts sustained over the course of the CDS Phase II diminished the scope of what it could (and should be expected) to achieve.

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[106] According to Health Canada officials, solvent abuse may include inhaling adhesives (e.g. glue) and aerosols, as well as solvents; a more encompassing term is "inhalants."

[107] This is further discussed under the next heading, Impact of Cuts.

Interviewees noted that cuts had the following specific impacts:

- delays: cuts resulted in delays in completing information systems.
- knowledge loss: cuts eclipsed the opportunity to learn from the CDS Phase II particularly as results were starting to cumulate in the latter part of the strategy.
- trust: the credibility of Health Canada's relationship with provinces, community partners, and client groups had been jeopardized by funding freezes.
- loss of expertise: a perception that staff departures and reassignments due to cuts have eroded the level of substance abuse expertise residing within Health Canada[108].
- with respect to the CCSA, it was funded 100% by the federal government in 1992. Now only 60% of their funding is directly from the CDS Phase II - provincial and private sector contributions, and specific contract resources (e.g. from the federal government) have made up the balance.

Impact of Non-Renewal

Interviewees (with one exception) were uniform in stating that non-renewal would have an overwhelmingly negative impact on the profile of substance abuse issues in Canada. Most interviewees implicitly or explicitly stated that substance abuse issues should be a priority at the national level, because of the harm it causes individuals, families, and Canadian society. Without a sustained focus on substance abuse issues, progress on this issue will regress. Several interviewees believe that Canadians may witness an increase in substance abuse problems, such as an increase in consumption among youth as is happening in the United States. Problems within high risk groups will continue.

Some interviewees pointed out that there has not been a public announcement regarding the non-renewal of the CDS, and that more community-level reaction will register once this fact is more widely-known.

Many interviewees expressed concern about the non-renewal of the Canadian Centre for Substance Abuse, which is seen to have made important gains in building and disseminating a knowledge base on substance abuse issues, in spite of federal spending cuts it has sustained.

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[108] Note: we cannot objectively determine whether this is the case, due to difficulties in tracking CDS-related personnel since the abolition of the CDSS and the reorganization within Health Canada.

The following comments about the impact of non-renewal were commonly made:

- loss of a national profile: without a national focus (e.g. setting national standards, directions), interviewees feel there will be a loss of expertise developed, and fragmentation in the approaches to substance abuse issues across the country.
- weakened coordination, in the area of prevention programming, as well as weakened collaboration between prevention and law enforcement.
- coordination will not be aversely affected in Aboriginal programming and health protection areas, as coordination was primarily achieved through existing structures.
- information systems won't be as complete.
- loss of an international profile and influencing role: Canada's position on substance abuse has been regarded as very well balanced and innovative. Consequently, Canada has been able to influence the international agenda (e.g. laying the groundwork for a U.N. Declaration on the Principles of Prevention). 1998 is a year of focus on drugs within the U.N. and without a strategy in place Canada's credibility in this field will be undermined, and it may be perceived as breaking its commitment to address this issue. This is particularly important, given that there is growing support within organizations such as the U.N. and the O.A.S. for a hemispheric strategy.
- the demand reduction focus will be lost, and the problem may become redefined as a supply/reduction and law enforcement issue, which runs counter to current thinking.
- collapsing substance abuse concerns into the population health model (and subsequently into other initiatives, such as AIDS) may also contribute to fragmentation and the HIV/AIDS dimension of substance abuse may assume a disproportionate priority over other aspects of substance abuse.
- the alcohol industry will face decreasing challenge and opposition, and they will take advantage of this to boost consumption of their products.
- drug testing backlogs could occur and result in a negative impact on the criminal justice system and the processing of criminal cases.
- within respect to Aboriginal populations, there is concern that the off-reserve focus (regarded as one of CDS's successes, by many) will be more vulnerable.

There is also concern that a focus on youth could be lost in communities at large.

Alternatives

Interviewees were generally unable to provide a sense of alternatives to federal funding.

With respect to the CCSA, it was noted that its dependence on federal funding has shifted from 100% to 60%; its sustainability remains in serious question.

Some interviewees stated that they are not confident that substance abuse issues will be appropriately addressed within Health Canada's Population Health Model. Many of the concerns centred on a) the abstract nature of the Population Health Model and whether it can, in fact, be put into practice and b) whether substance abuse issues will in any case lose out in competing for scarce resources amongst higher profile health issues (such as AIDS).

TECHNICAL APPENDIX

HEALTH CANADA OFFICIALS AND FEDERAL PARTNER INTERVIEWS REPORT

A. Health Canada Officials and Federal Partners Interview List

B. Health Canada Officials and Federal Partners Interview Guide

A. Health Canada Officials and Federal Partners Interview List

Health Canada

Jim Anderson
Program Consultant
Office of Alcohol, Drugs and
Dependency Issues
Health Canada

Denise Annett
Program Consultant
Directorate Policy and Contribution Coordination
Health Promotion and Programs Branch
Health Canada

Colin Broughton
Regional Director
Ontario Region
Bureau of Drug Surveillance
Health Protection Branch

Janet Binks
Senior Advisor, Healing and Wellness
Health Programs Support Division
Medical Services Branch
Health Canada

Pete Conley
Consultant
Planning and Management Office
Division of Aging and Seniors
Population Health Directorate
Health Promotion and Programs Branch
Health Canada

Mike DeGagné
Sr. Negotiator Labrador Inuit Association Claim
Indian and Norther Affairs Canada
(formerly with Medical Services Branch, Health Canada)

Ken Horsman
Consultant
Prairies Regional Office
Health Promotion and Programs Branch
Health Canada

Diane Jacovella
Manager
Office of Alcohol, Drugs and
Dependency Issues
Health Canada

Odette Johnson
A/Manager, Prevention
Medical Services Branch
Health Canada

Johanna Laporte
Program Officer
Marketing and Partnership Division
Research and Program Policy Directorate
Health Promotion and Programs Branch
Health Canada

Bruce Lodge
Head, Chemistry Section
Pharmaceutical and Chemistry Division
Banting Research Centre
Bureau of Drug Research
Health Protection Branch

Betsy MacKenzie
National Prevention Research Consultant
Prevention and Community Action Programs
HIV/AIDS Policy Coordination and Programs Division
Population Health Directorate
Health Canada

Patricia MacNeil
Research and Policy Analyst
Program and Policy Analysis Division
Research and Program Policy Directorate
Health Promotion and Programs Branch
Health Canada

Ziggie Malyniwsky
Organization of American States
(former Executive Director CDS Secretariat
Health Canada)

Cathy Mattern
Policy Analyst
Women's Health Bureau
Health Canada

Sandra Murray
Consultant, Health Education
Work and Education Health Promotion Unit
Healthy Living and Environments Division
Systems for Health Directorate
Health Promotion and Programs Branch
Health Canada

Michel Perron
(formerly with CDS Secretariat)
Senior Policy Analyst
Law Enforcement Strategy Group
Policy & Law Enforcement Directorate
Solicitor General Secretariat

Irene Rose
Program Consultant, Atlantic Regional Office
Health Promotion and Programs Branch
Health Canada

Judith Ross
A/Director
Health Programs Support Division
Medical Services Branch
Health Canada

Bruce Rowsell
Director
Bureau of Drug Surveillance
Health Protection Branch

Roy Sampson
Manager
Management Planning and Coordination Directorate
Planning and Coordination Division
Health Promotion and Programs Branch
Health Canada

Canadian Centre for Substance Abuse

Jacques LeCavalier
Executive Director
Canadian Centre on Substance Abuse

Treasury Board Secretariat

David Chaikoff
Review Analyst
Treasury Board Secretariat

Federal Partners

Helen Banulescu
Chief, Law Enforcement Group
Police and Law Enforcement Directorate
Policy and Research Division
Solicitor General Canada

Chief Superintendent René Charbonneau
Officer-in-Charge
Drug Enforcement Branch
Royal Canadian Mounted Police

Judith Huska
Coordinator, International Drug Issues
Foreign Affairs and International Trade

Brian Jonah
Chief, Road Users
Road Safety Directorate
Transport Canada

Lisa Svoboda
Deputy Director, Corporate Communications Division
Foreign Affairs and International Trade

B. Health Canada Officials and Federal Partners Interview Guide

Introduction

Interviewers will provide the following background information before commencing the interview:

Canada's Drug Strategy is a 5-year, interdepartmental initiative which began in 1992 and ends March 31, 1997. It builds on the work of its predecessor Initiative, the National Drug Strategy, that began in 1987 and ended in 1992.

The CDS Phase II is designed to improve the effectiveness of Canada's substance abuse programming. *It was to do so by enhancing coordination, improving the knowledge base for making program and policy decisions, and targeting resources to sub-populations at higher risk for substance abuse, and supplementing program resources.*

Health Canada has served as the lead department in this Initiative. Our firm, Jamieson Beals Lalonde, has been contracted to evaluate the effectiveness of the CDS Phase II in strengthening prevention and enforcement and control programming. We're concentrating on Health Canada's role in enhancing programs through improved targeting, enhancing coordination at all levels, and improving the knowledge base on substance abuse issues.

Before we start our interview, I'd like to assure you that your interview is confidential, and you will not be identified individually in the report.

Orientation

1. How familiar are you with the CDS Phase II? What has been your role in, and involvement with the CDS Phase II?

   Role:

   Level of Involvement

   Time period:

Intentions/Achievements CDS

2. In your opinion, how did the CDS Phase II intend to strengthen Health Canada Programming in Prevention & Enforcement and Control? (What were the key strategies and the relative importance of each one, i.e. targeting, coordination, information and resources?) What do you see as the key differences between Phase I and II?

3. In your opinion, what has the CDS Phase II enabled Health Canada programming to achieve? (Were prevention, enforcement and control programs strengthened under CDS Phase II? If so, what was accomplished, and how was it achieved?)

4. What non-CDS factors were at play in the accomplishments/problems that developed under CDS Phase II?

Targeting

One of the strategies for enhancing programming was to target at-risk populations. This was a shift from the original focus on general population programming.

5. What was the rationale for this shift in focussing?

6. What at-risk population groups were to be the target groups for CDS Phase II programming?

7. Given your experience with the CDS Phase II, was the shift to targeting at-risk group(s) actually made? (Give examples/evidence of shift.)

8. Were there differences in targeting at-risk populations in different activity areas (e.g. social marketing, education and training, research and information development, community based funding, national program/policy development)?

9. Was programming in CDS Phase II more effective as the result of targeting? If so, how?

10. Are the current target populations still relevant? If so, are current targeting strategies appropriate?

11. Are there other targets that are more relevant? If so, why?

12. What have we learned from the shift to targeting at-risk populations?

Coordination

The CDS Phase II intended to improve coordination and cooperation at many different levels, including within Health Canada, across Federal Departments, and with other partners, and between prevention and enforcement/control programs and policies.

13. Why were improvements needed, and how was coordination and cooperation initially conceived at the launch of CDS Phase II? (What levels/types of coordination were considered the most necessary/important/critical?)

14. What was the enhancement of coordination and cooperation intended to achieve? (Were there objectives, and if not, what did you understand the goals to be?)

15. What were your expectations of the role of the CDS Secretariat in terms of coordinating the strategy?

16. In your opinion, were CDS Secretariat resources adequate to meet these expectations?

17. How was coordination and cooperation operationalized?

    i. What (formal and informal) mechanisms were established under CDS Phase II to achieve coordination and cooperation? (What were the specific coordination roles of these mechanisms?)

    ii. How effective were these mechanisms?

iii. Would these coordination mechanisms have occurred without the CDS Phase II?

18. What were the improvements to coordination and cooperation that resulted from the CDS Phase II?

Within Health Canada

With federal partners

With other government (prov/terr) partners

Internationally

Nationally

Regionally

At the Community Level

19. Did coordination and cooperation under Phase II add value? What were the benefits? What were the downsides?

i. Did targeting of programs impact on coordination/collaboration between CDS Phase II and other Health Canada Initiatives? (If so, how?)

20. How satisfied were you, with the degree of coordination and cooperation achieved?

21. Is on-going coordination and cooperation needed? If so, how should it be operationalized? If not, why not?

22. The CDS Secretariat was abolished in 1996. What has been the impact of this change on coordination and on your program.

23. What would be the impact on non-renewal on coordination/cooperation in this field?

24. **FOR HC INTERVIEWEES ONLY:** What were the lines of departmental authority/accountability under CDS, and were they clear? effective?

Information Base

The CDS Phase II was intended to improve Canada's information base on drug-related issues. Specifically, in your area:

25. How was the development/enhancement and/or dissemination of information to be improved under CDS Phase II? (Please address both data collection and other types of information enhancement activities, and distinguish between traditional and non-traditional information collection/dissemination strategies.)

26. What types of information were to be enhanced? (e.g., information on at-risk populations (if so, which ones), etc.)

27. What improvements in collecting/disseminating information were actually made? (If none, why not?)

28. How have these improvements to the information base increased what we know about the following areas:

    i. Risk factors re: substance use/abuse

    ii. At-risk populations (Children, Youth, Young Adults, Out of the Mainstream Youth, Women, Seniors, Off-Reserve Aboriginal people, People at risk of Driving While Impaired (first and subsequent offenders)

    iii. Patterns/trends re: alcohol and other drug use in Canada

    iv. Assessing harm and costs of alcohol and drug use.

    v. Resiliency factors.

    vi. Other

29. What significant information gaps remain?

30. What specific improvements have been made to dissemination of information? (Are there differences between Phase II and Phase I in terms of how information is communicated?)

31. What information was disseminated, and to whom? (Please clarify the type of product, the audience for the product, and the dissemination methodology used.)

32. How has the improved information been used and by whom? (Please cite evidence of use, such as development/change re: protocols, policy statements, regulations, laws, practise, types of projects proposed/funded, programs developed.)

33. Have improvements to the information base had an impact on Health Canada's Programming? If so, what kind(s) of impact. If not, why not?

34. What specific impact has improved information/dissemination had on prevention programming and/or enforcement/control programming?

    i. Was information produced under CDS Phase II used in practise? (e.g. targeting of social marketing/communications & community action projects, modifications/development of legislation/regulations, etc.)

    ii. What has been the impact of improved information development under CDS Phase II on related areas such as AIDS, Family Violence, Women's Health, Seniors, or others?

    iii. Have there been any obstacles in using information to enhance programming? (Examples may include timing of information collection, dissemination problems, lack of clarity, timeliness, relevancy of information, etc.)

35. Have improvements to the information base had an impact on external partner programming?

Resources

36. How were Health Canada's CDS Phase II resources in your area used? (Please comment on allocation of resources between specific at-risk groups, activity areas, and prevention/enforcement/control programming.)

37. What did the increased resources enable you to achieve, that you wouldn't have been able to do otherwise?

38. Has Phase II made programs more cost-effective than they were in Phase I? If so, how?

39. What was the impact of CDS Phase II resource cuts?

40. What will be the impact of non-renewal on Health Canada's drug-related programming?

41. Are there other alternatives to CDS Phase II resources?

42. Do you have any other comments or concerns?